

Major Applied
Research Paper 1,
Technical Paper 1

The Dynamics of Policy Change: Health Care Financing in South Africa, 1994–1999

November 1999

Prepared by:

Lucy Gilson
Centre for Health Policy
University of Witwatersrand

Jane Doherty
Centre for Health Policy
University of Witwatersrand

Di McIntyre
Health Economics Unit
University of Cape Town

Stephen Thomas
Health Economics Unit
University of Cape Town

Vishal Briljal
Centre for Health Policy
University of Witwatersrand

Chris Bowa
Health Economics Unit



Partnerships
for Health
Reform



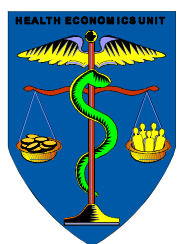
Abt Associates Inc. ■ 4800 Montgomery Lane, Suite 600
Bethesda, Maryland 20814 ■ Tel: 301/913-0500 ■ Fax: 301/652-3916

In collaboration with:

Development Associates, Inc. ■ Harvard School of Public Health ■
Howard University International Affairs Center ■ University Research Co., LLC



Funded by:
U.S. Agency for International Development





Partnerships
for Health
Reform

Mission

The Partnerships for Health Reform (PHR) Project seeks to improve people's health in low- and middle-income countries by supporting health sector reforms that ensure equitable access to efficient, sustainable, quality health care services. In partnership with local stakeholders, PHR promotes an integrated approach to health reform and builds capacity in the following key areas:

- ▲ *Better informed and more participatory policy processes in health sector reform;*
- ▲ *More equitable and sustainable health financing systems;*
- ▲ *Improved incentives within health systems to encourage agents to use and deliver efficient and quality health services; and*
- ▲ *Enhanced organization and management of health care systems and institutions to support specific health sector reforms.*

PHR advances knowledge and methodologies to develop, implement, and monitor health reforms and their impact, and promotes the exchange of information on critical health reform issues.

November 1999

Recommended Citation

Gilson, Lucy, Jane Doherty, Di McIntyre, Stephen Thomas, Vishal Brijlal, Chris Bowa and Sandi Mbatsha. 1999. *The Dynamics of Policy Change: Health Care Financing in South Africa, 1994-1999*. Major Applied Research Paper 1, Technical Paper 1. Bethesda, MD: Partnerships for Health Reform Project, Abt Associates Inc.

For additional copies of this report, contact the PHR Resource Center at pub_order@phrproject.com or visit our website at www.phrproject.com.

Contract No.: HRN-C-00-95-00024

Project No.: 936-5974.13

Submitted to: USAID

and: Robert Emrey, COTR
Policy and Sector Reform Division
Office of Health and Nutrition
Center for Population, Health and Nutrition
Bureau for Global Programs, Field Support and Research
United States Agency for International Development

Abstract

This report presents the findings of the South African country study undertaken as part of a two country project called Analysing the process of health sector reform in South Africa and Zambia (also known as ‘the SAZA project’).

The report presents an analysis of the experience of seeking change in health care financing policy in South Africa over the period 1994-1999, the first term of the country’s first democratic government.

Health financing reforms which aim to improve resource availability and use are a central component of the current wave of health sector reforms both in sub-Saharan Africa and in other parts of the world. However, there has been little systematic evaluation of reform experience in any country. This study was, therefore, initiated in order to better understand the process of developing and implementing such reforms and so to generate information which may support policy makers and planners both in the countries of focus and around the world.

The study was undertaken in South Africa and Zambia, two sub-Saharan countries which have introduced wide-ranging health financing changes in recent years. The experience of these countries is expected to be of relevance to other countries within the region and around the world.

The study has three important features that distinguish it from other research on health reforms in middle and low income countries:

1. The major contribution of the study is its emphasis on the process by which policies are developed and implemented, and the factors facilitating or constraining their impact (where ‘process’ covers the steps of policy change, their timing and the strategies used within these steps to, for example, build legitimacy, consensus or capacity, as well as the specific mechanisms or bodies established to take forward any of the steps);
2. The study has also considered the linkages between different financing reforms, and between financing reforms and other health sector reforms (in particular, decentralisation), to ensure a comprehensive understanding of reforms;
3. The study has focussed on the issues of equity and health system sustainability, which have been subjected to less scrutiny internationally than, for example, efficiency.

The range of reforms that have been considered are:

- ▲ geographic resource allocation formulae;
 - ▲ user fees (in South Africa the removal of primary care fees and in Zambia the implementation of a full fee schedule);
 - ▲ health insurance options (in South Africa, formal social health insurance and in Zambia, less formal, pre-payment schemes).
-

Foreword

Part of the mission of the Partnerships in Health Reform Project (PHR) is to advance “knowledge and methodologies to develop, implement, and monitor health reforms and their impact.” This goal is addressed not only through PHR’s technical assistance work but also through its Applied Research program, designed to complement and support technical assistance activities. The program comprises Major Applied Research studies and Small Applied Research grants.

The Major Applied Research topics that PHR is pursuing are those in which there is substantial interest on the part of policymakers, but only limited hard empirical evidence to guide policymakers and policy implementors. Currently researchers are investigating six main areas:

- ▲ Analysis of the process of health financing reform
- ▲ The impact of alternative provider payment systems
- ▲ Expanded coverage of priority services through the private sector
- ▲ Equity of health sector revenue generation and allocation patterns
- ▲ Impact of health sector reform on public sector health worker motivation
- ▲ Decentralization: local level priority setting and allocation

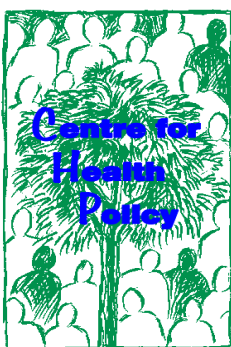
Each Major Applied Research Area yields working papers and technical papers. Working papers reflect the first phase of the research process. The papers are varied; they include literature reviews, conceptual papers, single country-case studies, and document reviews. None of the papers is a polished final product; rather, they are intended to further the research process—shedding further light on what seemed to be a promising avenue for research or exploring the literature around a particular issue. While they are written primarily to help guide the research team, they are also likely to be of interest to other researchers, or policymakers interested in particular issues or countries.

Ultimately, the working papers will contribute to more final and thorough pieces of research work, such as multi-country studies and reports presenting methodological developments or policy relevant conclusions. These more polished pieces will be published as technical papers.

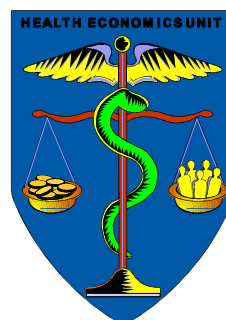
All reports will be disseminated by the PHR Resource Center and via the PHR website.

Sara Bennett, Ph.D.
Director, Applied Research Program
Partnerships for Health Reform

The following report, *The Dynamics of Policy Change: Health Care Financing in South Africa, 1994–1999*, is a joint effort of the USAID Partnerships for Health Reform Major Applied Research program, the Centre for Health Policy of the University of Witwatersrand, and the Health Unit of the University of Cape Town. The report, originally published as a monograph by the University of Witwatersrand, is reproduced in its entirety.



**Centre for Health Policy
University of the Witwatersrand**



**Health Economics Unit
University of Cape Town**

**ANALYSING THE PROCESS OF HEALTH FINANCING REFORM
IN SOUTH AFRICA AND ZAMBIA**

SOUTH AFRICA COUNTRY REPORT

**THE DYNAMICS OF POLICY CHANGE:
HEALTH CARE FINANCING IN SOUTH AFRICA,
1994 – 1999**

Lucy Gilson¹, Jane Doherty¹, Di McIntyre², Stephen Thomas², Vishal Brijlal¹, Chris Bowa¹ and Sandi Mbatsha²

1. Centre for Health Policy, University of Witwatersrand
2. Health Economics Unit, University of Cape Town

NOVEMBER 1999

Monograph 66

**CENTRE FOR HEALTH POLICY
UNIVERSITY OF THE WITWATERSRAND
PO BOX 1038
JOHANNESBURG 2000
South Africa**

Tel. +27-11-489.9936

Fax. +27-11-489.9900

Internet www.healthlink.org.za/chp

INFORMATION SHEET

The 'SAZA' Project

This report presents the findings of the South African country study undertaken as part of a two country project called *Analysing the process of health sector reform in South Africa and Zambia* (also known as 'the SAZA project').

The report presents an analysis of the experience of seeking change in health care financing policy in South Africa over the period 1994-1999, the first term of the country's first democratic government.

Why was the study undertaken?

Health financing reforms which aim to improve resource availability and use are a central component of the current wave of health sector reforms both in sub-Saharan Africa and in other parts of the world. However, there has been little systematic evaluation of reform experience in any country. This study was, therefore, initiated in order to better understand the process of developing and implementing such reforms and so to generate information which may support policy makers and planners both in the countries of focus and around the world.

Where was the study undertaken?

The study was undertaken in South Africa and Zambia, two sub-Saharan countries which have introduced wide-ranging health financing changes in recent years. The experience of these countries is expected to be of relevance to other countries within the region and around the world.

What makes the study different?

The study has three important features that distinguish it from other research on health reforms in middle and low income countries:

1. The major contribution of the study is its emphasis on the *process* by which policies are developed and implemented, and the factors facilitating or constraining their impact (where 'process' covers the steps of policy change, their timing and the strategies used within these steps to, for example, build legitimacy, consensus or capacity, as well as the specific mechanisms or bodies established to take forward any of the steps);
2. The study has also considered the *linkages* between different financing reforms, and between financing reforms and other health sector reforms (in particular, decentralisation), to ensure a comprehensive understanding of reforms;
3. The study has focussed on the issues of *equity* and *health system sustainability*, which have been subjected to less scrutiny internationally than, for example, efficiency.

What are the reforms of interest?

The range of reforms that have been considered are:

- * geographic resource allocation formulae;
- * user fees (in South Africa the removal of primary care fees and in Zambia the implementation of a full fee schedule);
- * health insurance options (in South Africa, formal social health insurance and in Zambia, less formal, pre-payment schemes).

Who has conducted the study?

A multi-disciplinary research team of health economists and health policy analysts has been involved, linking research institutions in two African and two European countries. The institutions are: Centre for Health Policy, University of the Witwatersrand (South Africa); Department of Economics, University of Zambia (Zambia); Health Economics Unit, University of Cape Town (South Africa); Health Policy Unit, London School of Hygiene and Tropical Medicine (UK); Institute of Health Economics (Sweden).

EXECUTIVE SUMMARY

What is this report about?

The first democratically elected South African government took office with a mandate to undertake wide-ranging and radical change in order to redress the apartheid legacy of inequity and inefficiency. Although much has been done, much inevitably remains to be done in order to ensure *"delivery to the poorest of the poor"* in all sectors, including health¹. Health care financing change is a critical component of wider action to tackle the apartheid health legacy as financing issues are central to health system development. These issues include the level of funding available for health care provision as well as the ways in which health care funds are channelled through the health system. They strongly influence patterns of both provision and utilisation, and so have important consequences for the quality of care, the efficiency of resource use and the equity of the health system. Not surprisingly, Health Minister Tshabalala-Msimang has included financing-related issues, such as social health insurance and increasing the number of 'fee paying' patients in public hospitals, within the health sector's ten priorities for the next five years².

A key foundation for developing future policy actions is evaluation of past experience. This report provides such an evaluation, focussing specifically on health care financing reform between 1994 and 1999. It suggests that while the government initiated a radical overhaul of the health system within its first five years, in terms of health care financing there were also setbacks and lost opportunities. More importantly, it tries to explain the strengths and weaknesses of financing policy-making as a basis for deciding what steps to take next.

Most evaluations are limited to issues of content, seeing the design of policies as the most important influence over their impacts. They focus on the 'what' of policy change. While this is useful it paints only half the picture. The 'black box' of policy development remains largely untouched. The particular value of this report is that it delves into that black box and examines the 'how' of policy change. It tries to understand what influence actors have had on the design and impact of reforms, and what their agendas were. It highlights the differing ways in which specific policies have been developed, drawing out the characteristics of these processes. Key contextual events and trends are also explored to understand policy decisions. Through this analysis, the study demonstrates that design problems and implementation failures are often rooted in weaknesses in the process of policy-making. Action to tackle the equity and sustainability problems within the health system must include not only specific pieces of analysis and design work, but also clear steps to strengthen policy-making around health care financing. This requires consideration of issues such as how policy design influences actors' support or opposition for reforms, what mechanisms and strategies to use in engaging different actors, and when to work with which actor. The impact and evolution of policy can never be disconnected from the manner in which it is developed.

¹ President Thabo Mbeki, in first speech as President to parliament, June 1999.

² 'Health Priorities in South Africa'. Report in *Izindaba. South African Medical Journal* 89(10), October 1999.

CHAPTER ONE

STUDY BACKGROUND

1.1 Justification

The need to evaluate health care financing reforms in sub-Saharan Africa

In the face of resource scarcity and inefficiency in resource use, changes in health care financing mechanisms have been a central element of the reforms introduced within public health systems across sub-Saharan Africa since the late-1970s. These reforms include resource mobilisation measures (such as the introduction or increase of user fees) and resource allocation mechanisms, and both represent and require major changes within public health systems.

Yet despite their importance, few evaluations of experience with these reforms were available by the mid-1990s. Most reported experience concerned cost recovery mechanisms and that experience had largely been disappointing (Gilson 1997a). Policies were often found to contribute little to their commonly stated goals of resource mobilisation and improved efficiency of resource use. At the same time, they had clear potential to impact adversely on other policy objectives, such as equity and health system sustainability. In some cases, the experience of implementing cost recovery mechanisms had led to policy reversal (Collins *et al.* 1996).

Even less was known about the factors that determined whether policies achieved their goals or about those factors that acted as blocks to goal achievement. Broader public sector reform experience suggested that the patterns of policy formulation and implementation were likely to be important influences (e.g. Grindle and Thomas 1991; Haggard and Webb 1993; Nelson 1990; Toye 1992). Delays and reverses in reform implementation had, for example, been shown to result from obstacles such as: conflict over policy goals between different interest groups; a lack of relevant information; and limits on the institutional capacity available to design and implement reforms. The key implication of these analyses is that understanding how such factors influence the pattern, pace and impact of reforms is important in strengthening reform efforts. Such understanding can, in particular, support early action to tackle potential obstacles, itself a critical element both in turning reform ideas into changes on the ground, and in bringing about positive impacts through these changes. As Brinkerhoff (1996: 1395) has said:

“Successfully pursuing long-term reforms in democratising environments involves not just knowing in which direction to move, but paying attention to how to get there”

Yet much health policy *“has been simply concerned with the technical features of policy content, rather than with the processes of putting policy into effect. As a result policy changes have often been implemented ineffectively and expected policy outcomes have not been achieved”* (Walt and Gilson 1994: 366).

1.2 Purpose, aims and objectives

This South African country study, therefore, sought to undertake in-depth analysis of the factors facilitating or constraining the potential of specific reforms to achieve change, in order to contribute to national and international policy debates concerning health care financing reforms. A second country study, in Zambia, was undertaken in parallel.

The overall aims of the project were to:

- strengthen the implementation of critical financing reforms in South Africa and Zambia;
- deepen international understanding of the factors facilitating and constraining the selected reforms' contribution to the broad performance goals of equity and health system sustainability.

Within the South African country study, the specific objectives were to:

- document the evolution of specific health care financing reforms in relation to (a) design, (b) steps in policy formulation and (c) initial implementation, as well as the linkages between individual reforms and between financing reforms and parallel institutional change;
- analyse retrospectively the critical factors facilitating and constraining the development and initial implementation of selected reforms;
- critically appraise the selected reforms' potential, or where possible, actual, contribution to the broad performance goals of equity and health system sustainability.

1.3 Areas of focus

Factors facilitating or constraining the development and implementation of health care financing reforms

A review of the few existing analyses of health reform experience was undertaken as a first step in this project (Gilson 1997b). It confirmed that the way in which health care financing reforms evolve is as likely to have a critical influence over the changes they generate, as the specific design of any reform.

Specific factors that have been found to influence the pattern, pace and impact of reform include:

- the importance of actors or stakeholders and their potential to block reforms - which is itself tied to the balance of power between different actors, often rooted in, and shaped by, conflict over the values and goals underlying reforms;
- the potential of reforms to alter the balance of power between actors as a result of the introduction of new or changed incentive structures;
- the strategies of policy development and implementation, including the differing contributions of incremental and radical implementation strategies in relation to different contexts – such as the potential of speedy implementation during a 'window of opportunity' to deliver change, but also the importance of building consensus and support for change through an incremental process;
- the mechanisms used in policy development as strategies for building consensus, legitimising reforms or even for deliberately delaying change (such as formal committees of inquiry);
- the importance of organisational capacity to successful reform - including both the formal skills and procedures within and between organisations, information and other resource availability and the informal social networks that promote common working practices and support achievement of organisational goals;
- the underlying contextual factors that shape the values underlying reforms and actors' behaviour, as well as determining the nature of selected reform proposals.

In general, Walt and Gilson (1994) suggest that these different factors can be categorised as four groups - factors of context, of the processes of policy formulation and implementation, of actors and of policy content or design. The term 'process' in this instance encompasses the steps in any

process of policy change (i.e. agenda-setting, design development, implementation and evaluation) and their timing, the strategies used within these steps to, for example, build legitimacy, consensus or capacity, as well as the specific mechanisms or bodies established to take forward any of the steps.

Features of reform design that influence impacts

Additional review of experience in implementing specific financing reforms further illustrates the two ways in which the design of any reform can influence the degree and nature of change achieved by the reform, that is, its impact. First, design details shape actors' responses to the reform – perhaps generating support or creating opposition. Second, through their influence over provider and user behaviour, the design details directly determine the equity and efficiency impacts of the reforms, as well as their sustainability. The design features of importance, by reform type, include:

(a) for resource mobilisation reforms e.g. user fees, pre-payment or social health insurance (Doherty 1997a; Gilson 1997a; Lake 1997):

- the fee or premium levels;
- the services for which fees are introduced or which are covered through pre-payment or social health insurance;
- the degree and range of exemption mechanisms within user fee systems, or the extent of risk sharing achieved through pre-payment and social health insurance;
- the mechanisms for using revenue use.

(b) for resource allocation mechanisms (Doherty 1997b):

- the criteria used to weight populations for need;
- the inclusion of 'special allocations' within formulae;
- the link between formulae components and the budget structure.

Past experience also hints at the potential influence of introducing financing changes singly or in combination, over their impact. Cost recovery mechanisms are, for example, commonly introduced without consideration of the complementary resource re-allocation mechanisms which are important in preventing the geographical inequities that could otherwise result from revenue retention at local levels. At the same time, the resource mobilisation potential of such mechanisms is likely to be enhanced by their linkage to pre-payment and other insurance mechanisms – especially at hospital level (Gilson 1997a).

In addition, the success of financing reforms seems to require implementation of a complementary package of institutional changes. Such changes include:

- the development of accounting and management capacities;
- decentralisation of revenue use control;
- quality of care improvements;
- re-designed information systems;
- effective community involvement in the design and management of financing schemes;
- the design of exemption mechanisms which target those unable to pay;
- stronger personnel recruitment and promotion practices.

Many analysts suggest that there is, for example, an important synergy between financing reforms and decentralisation of decision-making authority. This is tied, firstly, to the understanding that decentralisation can develop the managerial capacity required to allow effective implementation of new reforms. Bringing management closer to the population will allow the appropriate and efficient use of revenues raised through new resource mobilisation initiatives. Secondly, however, real decentralisation of authority may itself require financing reforms to mobilise or allocate resources to newly established decision-making bodies (Gilson *et al.* 1994). Effective implementation of financing reforms is likely, therefore, to require consideration of what responsibilities to decentralise, to whom and when. This 'sequencing' of reform implementation, the phased introduction of different changes over time and in recognition of their relevance to each other, is increasingly seen as an important element of successful reform (Leighton 1996). Whilst there are concerns about the dangers of initiating too much change at one time, some suggest that a comprehensive approach to reform will be more effective than piecemeal change (Gilson and Mills 1996; Mogedal *et al.* 1995).

Key implications for the project

Existing experience with health financing reform emphasises the importance of initiating early evaluation in order to guide, and fine-tune, the further development and implementation of these reforms. Whilst such evaluation should seek to measure the change achieved through reform (that is, their impacts), it is at least equally important that it specifically explores the factors that influence the nature and extent of change achieved. In other words, it is important to consider how the actors involved in the processes of design and implementation, as well as the design and the institutional context of any reform, shapes its impact. Such analysis can inform national and international policy-makers about how to manage processes of change more effectively and so enhance the extent of change achieved through reform.

Given the difficulty of disentangling the various factors influencing reforms, there is also growing recognition of the need for new evaluation approaches (Janovsky and Cassels 1996). The experience of undertaking a comprehensive assessment of financing reform can, thus, contribute to the development of approaches to explore the processes and context of policy-making and implementation, and by which to understand the less readily quantifiable impacts of reform.

1.4 Relevance of study to South Africa

The election of the first democratic government in South Africa in 1994 heralded an unprecedented wave of policy reform and institutional change across all sectors of government, including the health sector. 'Transformation' is the major imperative of the new South African government as it seeks to redress the apartheid legacy of poverty and inequality. In the health sector, the scale of the inherited inequities, which cut across the public/private divide of the health care system as well as geographical areas and population groups, pointed to the need for major structural re-organisation.

This evaluation of specific health care financing reforms in South Africa thus provides three opportunities. First, it allows investigation of these reforms as instruments for achieving health policy goals in South Africa. Second, it provides a window through which to understand the factors influencing the process of policy change in the newly democratic South Africa. Third, and finally, it provides inputs to the continuing development and implementation of actions to tackle the apartheid legacy in the health sector. Evaluation, especially the kind undertaken in this study, must be a critical element of the continuing current efforts to 'deliver' real changes in the health care available to all members of the population.

CHAPTER TWO

STUDY FOCUS AND APPROACH

2.1 Period and reforms of focus

The study's main period of focus was 1994-99, that is the term of the first democratic government of South Africa. However, the last six months of this period (roughly November 1998-April 1999) were less closely investigated because it was also the period during which the initial analyses of the study were being undertaken. The study also looked fairly closely at policy debates in the pre-1994 era (from around 1988), in order to understand the roots of post-1994 policy development.

Table 2.1 outlines both the health care financing reforms that have been the focus of this evaluation in South Africa and the parallel, institutional reforms that were considered.

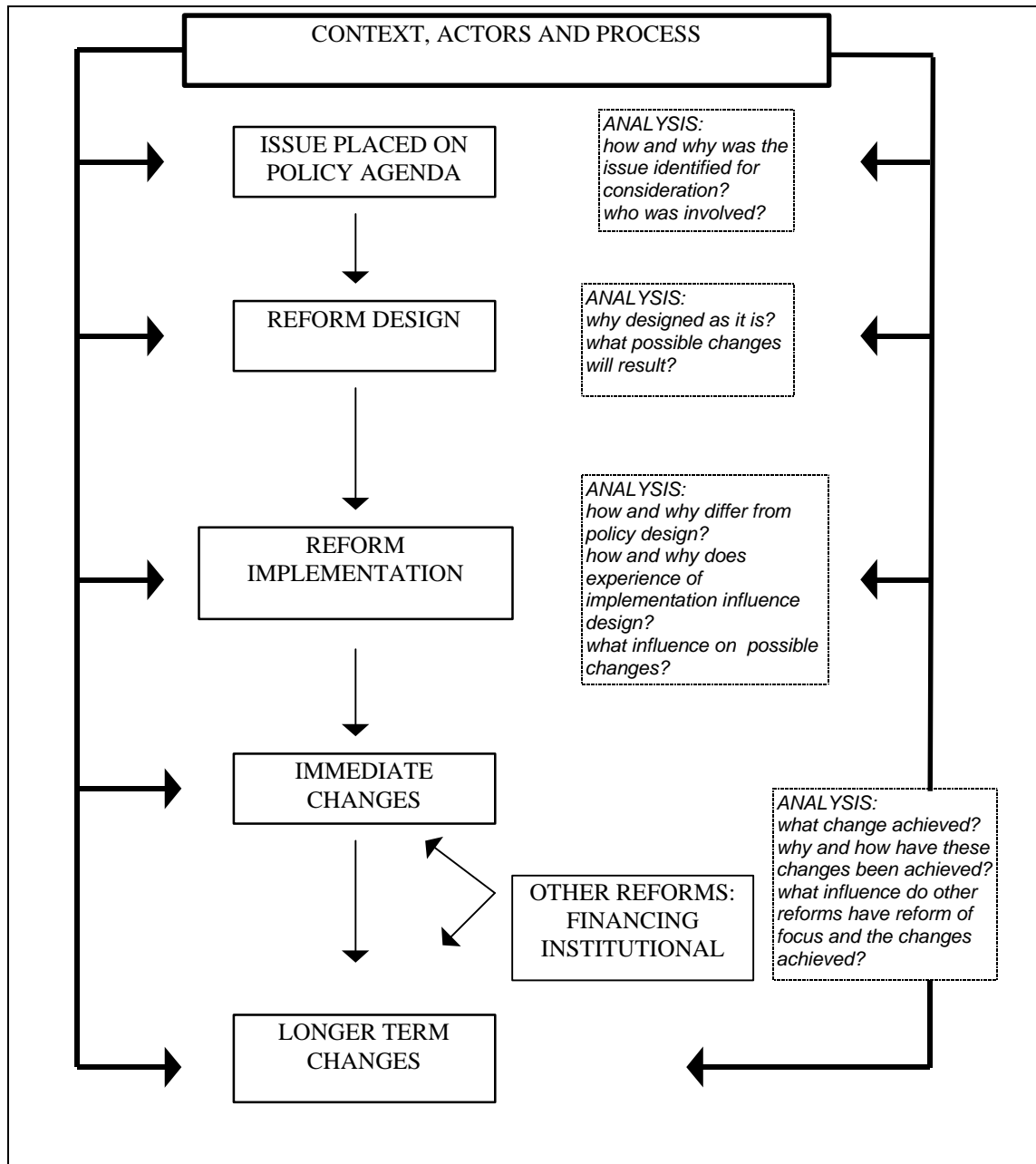
Table 2.1: Reforms of focus in South Africa	
<i>type of reform</i>	<i>Specific reform</i>
<i>resource mobilisation</i>	Removal of user fees for publicly-provided care for pregnant and nursing women and children under six (Free Care 1), and removal of user fees for primary care (Free Care 2)
	re-structuring of public hospital fees
	Development of proposals for social health insurance
<i>resource allocation</i>	development of inter-provincial resource re-allocation formulae
<i>parallel, institutional reforms</i>	creation of provinces within semi-federal state
	proposals to strengthen hospital management
	development of district health system

2.2 Conceptual framework and research questions

The framework developed to guide the overall project is summarised in Figure 2.1. For conceptual clarification the framework posits a linear process of policy change moving from agenda-setting around a reform of focus, to reform design and then through implementation to the achievement of immediate and longer-term changes. The framework's primary focus, however, is on detailed investigation at each step of what factors influence this apparently linear process and so, ultimately, shape the nature and extent of change achieved by the reform.

In investigating these factors, the framework points to the need to consider who or what causes an issue to be placed on the policy agenda and why specific reforms are designed in particular ways. Acknowledging that the nature of the reform is likely to change in unexpected ways through the process of implementation, it also allows such changes to themselves become a focus of enquiry.

Figure 2.1: The SAZA study's conceptual framework



Drawing on the policy analysis approach of Walt and Gilson (1994), the framework suggests that the factors influencing each of the steps in the reform process can be categorised into four broad groups:

1. factors of *context* (derived from Leichter 1979):
 - situational factors i.e. the specific conditions of a moment in history that impact on the policy changes of focus;
 - structural factors i.e. the relatively unchanging circumstances of the society and polity such as the structure of the economy and the political system;
 - cultural factors i.e. the values and commitments of society as a whole and groups within it;
 - exogenous factors i.e. the events and values outside any one country or system that influence it;
2. factors concerning *actors*:
 - who they are as well as their interests, values and roles in relation to the developing and implementing the reforms of focus;
3. factors of *process*:
 - the way in which the policies of focus are identified, formulated and implemented, including issues of consultation, timing and phasing;
4. factors of *content*:
 - the nature and design of the specific reform of focus;
 - the interaction between the financing reforms of focus and the interaction between these reforms and parallel institutional changes.

Overall, therefore, the conceptual framework highlights two sets of broad research questions (also translated into more detailed questions in Annex 2.1):

1. Analysing impact:

- what are the immediate and longer-term consequences of the reform?
- does it achieve its objectives?
- what are the potential consequences of the reform given its design? is it likely to achieve its objectives?

2. Understanding the 'policy process' as an influence over impact:

- how do factors of context, actors, process and content influence impact through the reform design and implementation process?
 - what factors determine the particular nature of the design of each reform and of the 'package' of reforms being taken forward within a country?
 - does the practice of implementation influence the design of the reform? how?
 - what factors explain how implementation practice differs from policy design?
 - what factors explain the (potential) immediate and longer-term consequences of the reform?
 - what influence do other financing and parallel institutional reforms have over the reform and its consequences?

2.3 Overview of research strategy and methods

2.3.1 Overall research strategy

Table 2.2 provides details of the key activities in each main phase of the research.

Table 2.2: Summary of research strategy		
Phase	Key foci	Data collection/analysis methods
1	<ul style="list-style-type: none"> delineation of key elements of reform context description of chronology of key events in reform evolution identification of key actors involved in reforms detailed description of the design of the reforms of focus 	<p><i>Data collection:</i></p> <ul style="list-style-type: none"> capture of researchers' own knowledge review of key policy documents and evaluation reports key informant interviews with informed and accessible policy-makers and policy analysts <p><i>Data analysis through:</i></p> <ul style="list-style-type: none"> development of 'timelines' for each reform of focus initial 'policy characteristics' analysis
2	<ul style="list-style-type: none"> detailed analysis of the factors facilitating and constraining the reforms of focus assessment of the potential or, where relevant, actual impact of reforms 	<p><i>Data collection:</i></p> <ul style="list-style-type: none"> key informant interviews with policy-makers and managers central to reforms generally or to specific reforms review of parliamentary debates and other documentary material from parliament media analysis collection of secondary data for impact analysis <p><i>Data analysis:</i></p> <ul style="list-style-type: none"> further use of selected policy analysis techniques e.g. stakeholder analysis, policy mapping techniques impact analysis through use of secondary data
3	<ul style="list-style-type: none"> draft and finalise country reports 	<p><i>Data collection and analysis:</i></p> <ul style="list-style-type: none"> the process of writing a draft report entailed further analysis and then elicited further information through the review process, information that was in turn fed back into report finalisation

An overview of key issues concerning the reforms of focus was undertaken in Phase 1, providing a foundation for the detailed analysis undertaken in Phase 2. The information collected in this phase also allowed the analytical questions guiding analysis to be revised and fine-tuned. Phase 2 then involved more detailed analysis of the key areas of focus, using a wider range of data analysis techniques and approaches and leading to a draft report. Finally, in Phase 3 the draft country report was developed, reviewed, revised and finalised.

2.3.2 Data collection and analysis methods

Table 2.3 gives more detail on the data collection methods used in the study and how the information derived from these methods was used in this study.

The study combined use of qualitative and quantitative methods of evaluation. Qualitative approaches were largely used in assessing the factors facilitating and constraining the reforms of focus, and qualitative and quantitative methods were combined in analysing the actual and potential impact of these reforms.

Table 2.3: Details of data collection methods

Data source	Details	Use
1. Researcher knowledge	2 of the research team were interviewed and made notes on their experiences within aspects of the policy processes of focus	<ul style="list-style-type: none"> • general, subject to validation through other data collected
2. Document review	<p>Documents used included:</p> <ul style="list-style-type: none"> • contributions to, and reports of, policy debates pre-1994; • academic analyses of reforms pre- and post-1994; • official post-1994 policy documents and policy input papers; • consultancy and evaluation reports on the reforms of focus <p>(see reference list and additional bibliography)</p>	<ul style="list-style-type: none"> • understanding the context of reform • development of timelines for reforms of focus • identification of design details of reforms of focus • some use in policy characteristics and stakeholder analyses
3. In-depth interviews	<p>28 in-depth interviews, of which:</p> <ul style="list-style-type: none"> 2 with ANC politicians; 6 with national government officials (health and non-health); 5 with provincial government health officials; 15 with policy analysts from sectors outside government. 	<ul style="list-style-type: none"> • understanding the context of reform • development of timelines for reforms of focus • identification of design details of reforms of focus • policy characteristics analysis, stakeholder analysis and other policy analysis techniques
4. Media analysis	<p>Review of health coverage in twelve South African newspapers, using material collected by two established clippings services (Stock Press and the Co-operative for Research and Education).</p> <p>The papers were: Business Report, The Business Day, The Cape Argus, The Cape Times, The Citizen, The Financial Mail, Financial Week, The Sunday Independent, The Sunday Times The Star, The Sowetan, The Weekly Mail and Guardian</p> <p>Also review of The South African Medical Journal.</p>	<ul style="list-style-type: none"> • understanding the context of reform • some use in policy characteristics and stakeholder analyses
5. Parliamentary data	<p>Review of official parliamentary debates on annual Minister of Health budget speeches;</p> <p>Review of national Portfolio Committee on Health reports</p>	<ul style="list-style-type: none"> • understanding the context of reform • some use in policy characteristics and stakeholder analyses
6. Published evaluations	See references.	<ul style="list-style-type: none"> • assessing impact of the two free care policies, and of resource re-allocation policies
7. Secondary data	Government budget and expenditure data	<ul style="list-style-type: none"> • for additional evaluation of the impact of resource re-allocation policies
8. Report review process	<p>Inputs received from:</p> <ul style="list-style-type: none"> 4 government officials/advisers (health) 4 analysts from sectors outside government 3 international specialists 	<ul style="list-style-type: none"> • input into all aspects of report

The first step in the study was to capture the important knowledge of the reforms and related processes held by two members of the research team. The aim was explicitly to identify these researchers' understandings and perspectives independently of other data collection efforts, allowing their views then to be tested and validated against other data, through specific analytical approaches.

A very full document review aimed to analyse as much relevant documentation as possible. Documents were selected on the basis of their importance across the reforms of focus, their ability to provide an historical perspective and their accessibility. A generic framework was used to guide the document reviews and ensure a common, but open, approach to analysis. Following review of a first set of documents an initial coding structure was derived from consideration both of the information collected and the study's conceptual framework. This structure was then applied to, and fine-tuned in, subsequent document reviews. It categorised the information collected through the document review in relation to issues of relevance to the study, allowing documentary data to be fed into subsequent analysis. These data were used initially by different members of the research team who developed, for each reform of focus:

- timelines identifying the key steps in each reform's development and implementation;
- an analysis of key, relevant factors of context, and key actors directly involved in the reform;
- analysis of the detailed design of each reform;
- an initial 'policy characteristics analysis' for each reform – this analysis considers the potential for the design of a reform to influence support or opposition for it, its ease of implementation and so, ultimately, shape its impact (Gustafson and Ingle 1992).

In-depth interviews formed the core of the data collection process in phase 2. Interviewees were selected purposively – ensuring that many of those directly involved in reform development and implementation were interviewed and that the perspectives of different groups were obtained (e.g. national and provincial government officials, government officials and analysts outside government). A snow ball process also allowed the first set of interviewees to identify important people who they suggested should be interviewed as part of a second group. The interviews were open-ended in nature, although a series of broad guiding questions was developed for use within them – and adapted appropriately to specific interviewees. Interviews were either taped and transcribed, or detailed notes made during the interview were typed up immediately following the interview by the interviewer. Each interview was then coded broadly using categories derived from consideration both of the information collected, the document review coding structure and the study's conceptual framework. Individual members of the research team then developed initial analyses of these data by reform of focus and by the four broad factors likely to influence their evolution (context, actors, processes, and design). Such analyses supplemented those undertaken through document reviews, adding more detail to understanding specific aspects of policy formulation and implementation, and the role of different actors. Stakeholder analyses, in particular, allowed assessment of the actors involved in, and missing from, reform processes, their interests and concerns and position on specific reforms (Crosby 1997).

Media analysis and review of parliamentary data supplemented both document review and interviews, generating additional information of relevance to the issues of focus. The media analysis was not, therefore, a full analysis of the influence of the media over policy debates.

Finally, data drawn from published evaluations and some limited, additional analysis of secondary data allowed the impact of reforms to be assessed (see also section 2.4). No primary data collection was undertaken for this study.

2.4 Assessing impact

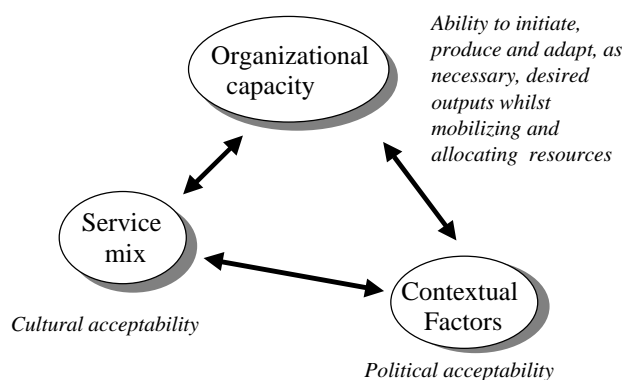
The study's assessment of the impact of the reforms of focus had four components. It sought to understand the impact of reforms on health equity and on health system sustainability. At the same time, it considered both the impact of the user fee and resource allocation reforms actually implemented in the period of focus (1994-99), as well as the potential impact of the social health insurance proposals developed but not implemented in this period.

The focus on equity is clearly of relevance in South Africa given the government's overall policy goal of redressing the social injustices of the past (see also **Chapter 3**). The specific objectives of the reforms of focus also illuminate the importance of equity as an objective by which to assess their impact (see Table 2.4). Whilst equity is a multi-faceted concept it is understood in this study as requiring consideration of the distribution both of the benefits and burdens of health care, and of the procedures by which those distributional decisions are made. The latter concern reflects a growing emphasis on procedural justice within an understanding of equity as, for example, applied to resource allocation debates (e.g. Gilson 1998a; Mooney 1996; Mooney 1998). It should be noted that although the Department of Finance's resource allocation formula is not a health sector policy it was considered within the study because of its influence on health resource allocation practices after 1996 (see **Chapter 4**).

Table 2.4: The stated objectives of the financing reforms of focus		
STATED OBJECTIVE	CLASSIFICATION ACCORDING TO IMPACT AREA	
	Health equity	Health system sustainability
<i>Free care for pregnant and nursing women, and children under six</i>		
to improve access to health services for pregnant and nursing women, and children under the age of six	✓	
to reduce maternal and infant mortality rates	✓	
to improve the health status of women	✓	
to promote family planning	✓	
<i>Free primary care for all South Africans</i>		
to improve access to basic health care for all South Africans	✓	
<i>The Department of Health's resource re-allocation formula</i>		
to distribute financial resources equitably between provinces	✓	
to shift resources away from higher towards lower level services	(✓)	(✓)
<i>The Department of Finance's resource re-allocation formula</i>		
to allocate public funds equitably and efficiently	✓	✓
to ensure the sustainability of public expenditure		✓
<i>Social health insurance proposals</i>		
to improve coverage and cross-subsidisation	✓	
to address the distortions of the private sector	✓	✓
to mobilise additional resources for the public health sector in a politically accepted way		✓
Note: bracketed ticks indicated an objective implicit in policy documents rather than one explicitly stated.		
Sources: African National Congress 1994a, 1994b; Department of Finance 1999; Department of Health 1994, 1996a, 1996b, 1997a; Health Care Finance Committee 1994; Ntsaluba and Pillay 1998; South Africa 1995; interview data.		

The Table also points to the relevance of sustainability as a policy objective against which to measure impact, even whilst suggesting it may be of less importance than equity in the South African context. This study, however, considered ‘sustainability’ as a critical aspect of the pursuit of social justice. Like equity, ‘sustainability’ has various aspects, and includes consideration of financial sustainability, combining the mobilisation of resources with improvements in allocative and technical efficiency, the political acceptability of reforms and the organisational capacity of the system to develop and implement reforms over time. Olsen (1998) has, for example, suggested that a health service is sustainable when operated by an organizational system with the long-term ability to mobilize and allocate sufficient and appropriate resources (manpower, technology, information and finance) for activities that meet individual or public health needs/demands. Figure 2.2 summarises the key aspects of health system sustainability considered in this study. Service mix can be understood as referring to the balance between levels of care in a health system. It influences health system ‘acceptability’ in relation to public demands, as well as public health needs.

Figure 2.2: Components of sustainability



In order to facilitate assessment against the two broad goals of equity and sustainability, several criteria were also identified for use in analysing the impact of reforms. Given data limitations, these criteria were used rather roughly. The equity criteria were:

(a) user fees:

- equal financial and geographical access/ utilisation for equal need;

(b) geographic resource allocation:

- equal expenditure per head of the ‘population’ between provinces, where the population used was only the uninsured population in line with the intention of the public health system to provide care to those who cannot afford private insurance. This criterion was recognised to fall short of measuring the different resource requirements of different populations. However, it was not possible to develop per capita estimates weighted for relative need - see also **Chapter 5**;

(c) social health insurance:

- extent of cross-subsidisation between insured and uninsured (and within insured population);
- equal access for equal need.

Across reforms the criteria broadly applied in assessing sustainability were:

- resource mobilisation levels/potential;
- the allocative efficiency of resource use;
- the acceptability of reforms to different stakeholders;
- the contribution of reforms to strengthening the health system's 'organisational capacity' (involving consideration of human resource availability, management systems, the networks of organisations involved in implementing a specific task and the broader institutional environment of these organisations: Hilderbrand and Grindle 1994).

For the reforms already implemented, analysis drew on relevant and available secondary data. However, as social health insurance had not been implemented by 1999, the analysis involved a critical appraisal of the design of key proposals in terms of their potential to promote equity and health system sustainability.

2.5 Ensuring rigour and validity in interpretative analysis

In analysis the research team was inevitably required to interpret the information it had collected in making a variety of judgements concerning both the actual and potential impact of the reforms of focus and the factors that have influenced their evolution and impact. Such interpretation cannot be avoided in a study of this kind and a variety of strategies were adopted to bring rigour and promote validity in the interpretative judgements that were made.

These strategies included:

- the involvement in the research team of both 'insiders' (researchers with detailed knowledge of the policy processes) and 'outsiders' (researchers with previously less involvement in the policy processes);
- developing and testing specific guidelines for review of all forms of documentation (including media analysis) and for in-depth interviews, based on the study's conceptual framework and their initial application;
- two steps of triangulation in data analysis – firstly, triangulation of information derived from a particular source of information (i.e. documents, interviews, media reports); and secondly, triangulation across these different sources of data;
- a careful and deliberate review process for the final draft report, allowing analyses to be tested against the judgments and views of South African key informants who have played a central role in relation to the reforms of focus and international reviewers with broader experience.

The process of data collection and analysis was, therefore, an iterative process, as summarised in Table 2.5. It required the research team to develop and refine interpretations and analyses, repeatedly testing individual researcher's judgements not only against those of other team members but also, more importantly, against those of the key informants involved in the final report review process.

Table 2.5: The iterative analytical process	
Activities of study	Steps in analysis and interpretation
<i>Team workshop 1 (October 1997):</i> Development of conceptual framework and overall research strategy >>	
>> Data collection phase 1 >>	Initial analyses: timelines, design details, contextual factors
<i>Team workshop 2 (March 1998):</i> Review of initial analyses >>	
>> Data collection phase 2 >>	Further analyses, including development of first input papers on each reform of focus
<i>Team workshop 3 (June 1998):</i> Review of first input papers >>	
>> Data collection phase 2 continuing >>	Further analyses, including development of input papers on factors of context, actors, processes and design across reforms of focus
<i>Team workshop 4 (Sept 1998):</i> Review of input papers >>	Preparation of draft one report chapters
<i>Team workshop 5 (January 1999):</i> Review of draft one chapters >>	Preparation of draft two report chapters
Review of draft two chapters by research team members and one international external reviewer >>	Preparation of draft three report chapters
Review of draft three chapters by South African and international reviewers >>	
<i>Team workshop 6 July 1999:</i> Discussion of reviewers' comments >>	Preparation of final report chapters

2.6 Use of data in the report

This report presents the final interpretation of health care financing reform experiences developed by the research team through the overall process of data collection, analysis and interpretation described above. It gives particular weight to the qualitative interview data that provide most insight on the central issues of the study – that is, the factors shaping the pattern and pace of reform, and their influence over impact. These interview data both underlie the interpretative analysis presented in the report - and are used directly (as specific quotations) to illustrate particular issues and perceptions. Documentary data were also used to supplement insights derived from the interview data, as referenced in the report. The specific quotes used in the report were deliberately selected either because they provide an example of a view commonly expressed, or because they reflect the view of a particular and important actor. In presenting these quotes, the anonymity of the respondents is preserved although, wherever possible, the respondent category (see Table 2.3) is identified.

Finally, the analysis of reform impact combines use of the research team's own analysis of available secondary data, published evaluation studies and their conclusions, as well as some interpretation of experience derived from interview data. The quotations used in this analysis were again selected, as described above.

2.7 Remaining methodological concerns

Despite the careful research process, four specific issues do influence the interpretative analysis presented in this report.

1. *The focus of the study:*

Through analysis of the information collected in this study it became clear that the focus on financing reforms gave the study a particular and, possibly, partial perspective on the overall process of health policy change in South Africa in the 1994-99 period. These particular reforms involved, for example, a different range of actors and groups than other health sector reforms. Whilst this study provides an insight into the broader process of health sector 'transformation' it does not, therefore, give a full view of that process. For example, it retains a clear focus on policy development at the national level because of the pattern of reform evolution in relation to both inter-provincial resource allocation and social health insurance. In addition, policies that are under development but are not yet widely known have not been fully reflected in this analysis.

2. *Researchers as past participants in policy processes:*

Recognising the role of some research team members in past policy processes, specific efforts were made to limit their potential influence over analysis and interpretation, as already discussed. This report, thus, presents the interpretation and judgements of the research team as a whole and not of specific members within it. However, there is some remaining potential for research team members' personal experiences to have coloured their judgements. Such experiences include not only direct involvement in past policy processes but also the continuing involvement of all team members in policy action, given the small and inter-linked government and non-government policy community. Clearly no analysis of this kind is entirely free of bias.

3. *Interviewee balance:*

Although efforts were made to ensure that those interviewed represented a balance of different perspectives, a higher proportion of analysts from outside government were interviewed than of government officials. This may have influenced the analysis presented here, although this pool of analysts itself includes a diverse range of people – working for academic, private, and non-governmental organisations. It also includes some people who were explicitly brought into policy processes under the new government, even if they were not directly employed by government.

4. *Interviewee access:*

The interviewee balance itself reflects some problems in accessing pre-identified government and political interviewees. Most importantly, it proved impossible to arrange interviews with either the Minister of Health of the period of focus, or her two Director Generals in the national Department of Health during this time. To offset this gap at least partially, efforts have been made to draw into the analysis publicly available interview data or materials produced by these individuals.

Annex 2.1: Analytical questions guiding data collection and analysis

1. What factors facilitate or constrain the likely effectiveness and impact of financing reforms?

Content:

- ⇒ what aspects of design for each reform of focus are most important to consider carefully because of their influence on the reforms' impact?
- ⇒ what linkages to other existing/planned reforms have been considered in developing the reforms of focus?
- ⇒ what are the respective benefits of introducing financing reforms singly or in a package?
- ⇒ if there is a clear difference between stated and underlying reform objectives, what significance does this have for the effectiveness of reforms and how effectiveness should be assessed?
- ⇒ what institutional changes are necessary to support the effective implementation of the reforms of focus? (who currently takes what decisions and how might this need to be adapted?)
- ⇒ what 'capacities' are necessary to allow effective decision-making in implementing the reforms of focus?

Actors:

- ⇒ which groups have supported and opposed the reforms and in what way, if any, has this support/opposition influenced the impact of the reforms?
- ⇒ how do the values of different groups influence their support or opposition for the reforms of focus?
- ⇒ which actors appear to have been most influential across reform or by reform? and why?
- ⇒ what incentives for behavioural change are introduced by the reforms of focus, and how do they influence effectiveness and impact?

Context:

- ⇒ in what way, if any, has the broad context of reform implementation influenced the design of reforms and their likely effectiveness?
- ⇒ what features of context appear to give which actors influence in the policy process?

Process:

- ⇒ is the impact of the reform influenced by the (non-)implementation the any parallel reforms?
- ⇒ what are the relative advantages and disadvantages of different implementation strategies, and how are these affected by the nature of the reform and the particular context of implementation?
- ⇒ what role can what types of information play in facilitating the process of reform?
- ⇒ what role can procedures for evaluating reforms play in furthering implementation?
- ⇒ what strategies have been used to generate support and counter opposition, and how successful have they been?
- ⇒ what steps can be taken to offset the possible negative impacts of reforms?
- ⇒ what are the most effective strategies for institutional reform and capacity development?

2. How can the impact of reforms be enhanced?

- ⇒ what conditions should be in place to achieve the achievement of objectives?
- ⇒ what adaptations of design and of implementation strategy are required?

CHAPTER THREE

THE CONTEXT OF HEALTH FINANCING REFORM

This chapter is organised according to the following categorisation of contextual influences: the historical context; political change; administrative restructuring; the new economic policy; and the new health structures and policy. Locating health financing reform in the 1994-99 period within the broader context of transformation in South Africa, the chapter provides a foundation for the analysis of all subsequent chapters.

3.1 The historical context

3.1.1 The apartheid state

Between 1948 and 1994, South Africa was governed by the National Party which was elected into power by a whites-only electorate. Under this regime, a policy of racial segregation and discrimination known as ‘apartheid’ was implemented systematically, although racial oppression had existed long before. An array of economic and social policies was assembled to protect white privilege¹. The most important policies are summarised in Box 3.1.

Box 3.1: The main apartheid policies that protected white privilege

- The Native Land Act of 1913 designated only 13 percent of the land as areas where blacks could buy and occupy land, becoming the foundation of the ‘homeland’ system.
- The ‘pass laws’ restricted the movement of the black population around the country in order to achieve ‘influx control’, that is, the restriction of access by blacks to urban areas and associated job markets.
- Education policies systematically limited skills development in blacks.
- Job reservation protected whites’ access to skilled and better paid jobs.

The country’s political and administrative system was structured along racial lines into ten ‘homelands’ where the majority of Africans lived, and four provinces of ‘white’ South Africa. There were approximately 800 local governments across the country. Rural areas had weak political and administrative structures and virtually all their services were organised at the provincial level. Humphries and Rapoo (1994) note that, despite the plethora of regional and local administrations, South Africa remained in practice a highly centralised state, with important decisions about policy, planning and budget allocation controlled by central government.

The majority of whites lived in cities that had a modern infrastructure and were served by well-funded schools and modern hospitals. Most urban African localities had much poorer services and large numbers of people lived in informal squatter settlements. Rural areas included approximately 45 percent of the population, most of whom were African (Central Statistical Services 1997). Access to public services was limited in these areas, and services

¹ The use of the terms ‘African’, ‘Asian’, ‘Coloured’ and ‘White’ indicates a statutory stratification of the South African population in terms of the former Population Registration Act. The use of these terms does not imply the legitimacy of this racist terminology, but is necessary in terms of any discussion of the South African system.

were generally of an inferior quality to those habitually enjoyed by the white population. Many of these structural differences persist today.

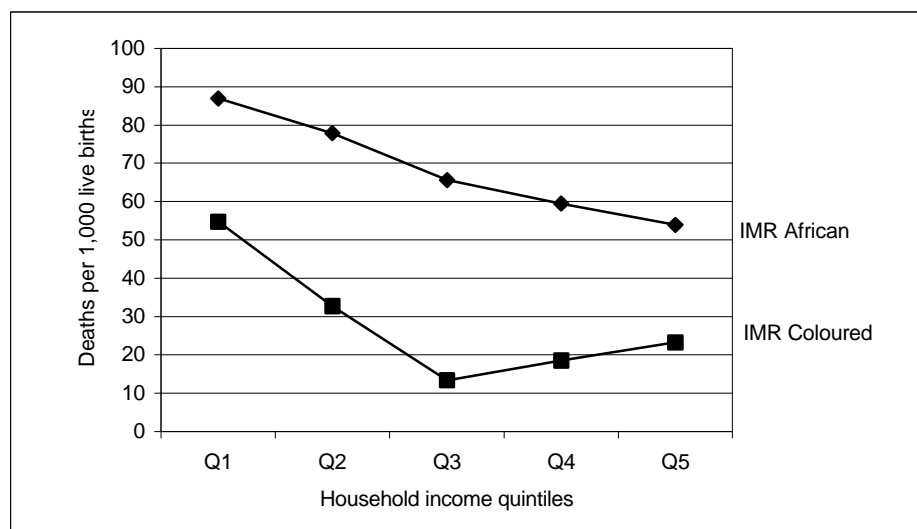
Indeed, poverty, and inequalities along racial lines are the most enduring legacies of the apartheid era. South Africa is one of the most inequitable societies in the world (Fallon and da Silva 1994). The government-sponsored Poverty and Inequality Report (May 1998) classified just over 50 percent of the population as 'poor' and 27 percent as 'ultra-poor'. The report found that the poorest 40 percent of the population enjoyed only 11 percent of total income. In 1995, the average household income of whites (who constitute approximately 11 percent of the population of 40.6 million) was 4.5 times that of the black population; urban households had double the average income of rural households; and average household income varied by nearly three times across provinces. These inequities occurred in the context of an upper-middle income country with a per capita gross national product in 1995 of US\$3,160 (World Bank 1997).

Table 3.1: Infant mortality rates by population group	
Population Group	Infant Mortality Rate (per 1,000 live births)
African	47.0
• urban	38.7
• non-urban	53.6
Coloured	18.8
White	(11.4)
Asian	*

Source: Medical Research Council *et al.* 1999

Note: Figures in parentheses are based on 250-500 cases, while an asterisk denotes a figure based on fewer than 250 cases that has been suppressed.

Figure 3.1: Infant mortality rate gradients across income quintiles for the African and Coloured population groups (Source: Gilson and McIntyre 2000)



Poverty produces health status patterns in some population groups that are characteristic of low-income countries, with important causes of mortality being preventable disease as well as accidents and violence (Bourne 1994). Notably, maternal mortality is high, at 150 maternal deaths per 100,000 live births (Medical Research Council *et al.* 1999). Inequities also result in striking differentials in health status between different race and income

categories. For example, the South Africa Demographic and Health Survey (1998) found an infant mortality rate for the ten years preceding the survey of 11.4 per 1,000 live births for Whites, and 53.6 for non-urban Africans (Medical Research Council *et al.* 1999; see also Table 3.1). Using household survey data² from the first half of this decade, Gilson and McIntyre (2000) show how, even within population groups, infant mortality experience consistently declines across household income levels (from wealthiest to poorest) (see Figure 3.1).

3.1.2 The apartheid health sector

Under apartheid, the health system mirrored general tendencies in government. The public sector was fragmented into a large number of overlapping administrative systems: each of the four racial groups had its own national department of health; every homeland and provincial administration had a department of health; and 400 local authorities also had health departments. Services were concentrated in urban areas, and focused on curative, hospital-based, specialised care. Thus, in 1992/93, acute care hospitals in general spent over 76 percent of total recurrent public health expenditure, with academic and tertiary hospitals accounting for 44 percent (McIntyre *et al.* 1995). Only 11 percent of funds were spent on primary care delivered outside the hospital setting.

In addition, and in line with general policies to promote privatisation and service the interests of the elite, South Africa's private health sector had been allowed to grow to substantial proportions by the mid-1990s. In 1992/93, nearly 61 percent of health care financial resources were derived from private funding sources (see Table 3.2), and the majority of health personnel worked in the private sector. However, only 23 percent of South Africans enjoyed some degree of access to private sector health care on a regular basis (McIntyre *et al.* 1995).

Table 3.2: Sources of finance for the health sector (1992/93)		
Source of finance	Expenditure (million Rands)	Percentage contribution (%)
General tax revenue	11,447	38.0
Local authorities revenue	225	0.7
Total public sector sources	11,672	38.7
Medical schemes	12,064	40.0
Medical insurance	923	3.1
Industry	1,162	3.8
Out-of-pocket	4,184	13.9
Total private sector sources	18,333	60.8
Donor funding	145	0.5
TOTAL	30,150	100

Source: McIntyre *et al.* 1995

Medical schemes were, and remain, the principal financial intermediaries in the private sector. These schemes are non-profit, voluntary associations funded primarily out of contributions from employers and employees. The large companies that administer them are profit making. Medical schemes reimburse medical expenses incurred by members, sometimes with a co-payment by members. Health service providers are paid on a fee-for-service basis, a system that is recognised internationally as encouraging over-provision of expensive services. For this and other reasons, cost escalation in the private sector typically exceeded inflation in the late 1980s and early 1990s, and caused several schemes to collapse.

² The 1993/94 Living Standards and Development Survey, and the 1995 October Household Survey (Hirschowitz and Orkin 1995).

Schemes typically responded to this crisis by limiting benefits, increasing co-payments, and creating different benefit packages with different contribution levels for members with different needs, thereby restricting access to medical scheme coverage by the most needy and heightening the problem of inequity. This was tolerated, and even facilitated, by the apartheid government that relaxed controls over the private sector through two amendments to the Medical Schemes Act in 1990 and 1994. Since the amendments, voluntary health insurance offered by life assurance and short-term insurance companies has grown rapidly from a small base, targeting low-risk individuals seeking limited cover.

These structural features of the public and private health sectors gave rise to striking inequities in health care provision. Table 3.3 presents, for example, selected indicators of public health sector resource allocation and use for the poorest and richest fifths of magisterial districts grouped by average per capita income, in 1992/93 (McIntyre *et al.* 1995). It is noteworthy that the poorest two quintiles contained almost half of the South African population and almost all of these people were African, most living in the former homelands. Many of those inhabiting the richest districts also enjoyed private sector care whilst simultaneously capturing significant public sector subsidies.

The broader package of apartheid policies also contributed to inequity in health care use. Gilson and McIntyre (2000) show that health care utilisation patterns in South Africa were sensitive to race, household income level, employment status, education status, household environmental health status, geographical area, and insurance status, rather than to health status, which would normally be expected to indicate need for health care. The only groups who achieved the target utilisation rate for primary care in South Africa of 3.74 visits per capita per year (Rispel *et al.* 1996),³ were the higher socio-economic groups and those with medical aid support.

Table 3.3: Indicators of the availability of public sector health care resources between magisterial districts (1992/93)		
Indicator	“Poorest” districts	“Richest” districts
Hospital beds/1,000 population	2.1	3.8
Population per clinic	16,260	12,442
Outpatient visits per capita	1.0	2.6
Doctors (general and specialist) per 100,000 population	5.5	35.6
Nurses per 100,000 population	188.1	375.3
Health inspectors per 100,000 population	1.1	6.7
Pharmacists per 100,000 population	0.5	5.4
Per capita health care expenditure (1992/93)	R122	R437

Source: McIntyre *et al.* 1995

Public health care resources were also distributed inequitably between the nine new provinces created in 1994. Table 3.4 ranks the provinces by expenditure per non-medical aid beneficiary in 1992/93. Mpumalanga, Northern Province and North-West spent less than R250 per capita on public health services. Gauteng, which was ranked at R631, spent three times as much per person as Mpumalanga, which was ranked last.

Table 3.4: Provincial distribution of public sector health care resources across the population excluding medical scheme beneficiaries (1992/93)

³ This guideline falls within the range of 3 to 4 visits proposed for developing countries by Gish (1990).

Province	Acute public hospital beds per 1,000 population	Population per public sector clinic	Public sector doctors per 100,000 population	Public sector nurses per 100,000 population	Total public sector health expenditure per capita (Rands)
Mpumalanga	2.29	10,485	9.26	206.18	181.45
North-West	2.74	8,409	12.12	313.52	229.06
N. Province	2.78	11,498	10.78	258.96	205.88
Eastern Cape	2.79	9,369	17.18	368.47	276.59
Free State	2.95	8,141	18.40	344.26	354.45
Northern Cape	3.63	5,437	9.79	235.70	250.57
KwaZulu-Natal	3.73	18,228	19.78	342.24	302.74
Western Cape	3.81	5,259	80.12	626.27	723.73
Gauteng	4.09	9,008	54.83	474.38	630.69
TOTAL	3.24	9,705	25.96	361.97	350.58

Source: Based on resource figures from McIntyre *et al.* 1995, but using population figures from the final 1996 census (Central Statistical Services 1997) worked back to 1992, using Demographic Information Bureau provincial population growth estimates, and excluding medical scheme beneficiaries as calculated from the 1995 October Household Survey.

Furthermore, the public sector was plagued by technical inefficiencies, stemming largely from outdated management and training practices inherited from the apartheid era (see, for example, Monitor Company *et al.* 1996bX?). This, in combination with a shortage of financial, human and physical resources, led to pervasive quality of care problems that persist to this day. All in all, despite spending 8.5 per cent of its gross domestic product on health care and achieving a per capita health expenditure of US\$247,⁴ South African health status indicators did not compare well with those of other middle income countries in 1992/93, the year before political change brought an end to the apartheid era (see Table 3.5).

Table 3.5: Data on health care expenditure and health status in South Africa pre-1994 and countries that have comprehensive health expenditure data

	Health expenditure as % of GDP*	Infant mortality rate** (per 1,000)	Life expectancy at birth 1991 (years)	Annual incidence of tuberculosis 1990 (per 100,000)
Middle-income countries				
South Africa	8.5	> 49	< 63	250
Colombia	7.3	23	69	67
Mexico	4.8	36	70	110
Philippines	2.4	41	65	280
Established market Economies	9.2	8	77	20

Sources: Expenditure data derived from McIntyre *et al.* 1995 and Berman 1997; Health indicator data derived from McIntyre *et al.* 1995; and World Bank 1993.

* Data for South Africa are for 1992/93, 1993 for Colombia, 1992 for Mexico, 1991 for Philippines, and 1990/91 for established market economies.

** Data on the infant mortality rate are for 1992 in South Africa and 1991 in the other countries

The health system that confronted the first democratic government in South Africa was thus riddled with inequities and inefficiencies. Both public and private health sectors faced major challenges to their long-term sustainability, especially in the face of a rapidly expanding

⁴ In 1992/93, the exchange rate was approximately R3 = US\$1.

HIV/AIDS epidemic that can be expected to place enormous demands on health care resources. Between 1997 and 1998 this epidemic demonstrated a national increase in the prevalence level of HIV infection of 33.8 percent, and by 1998 was estimated to infect one in eight adults (Department of Health 1998).

3.2 Political change

3.2.1 The negotiated settlement and the concept of power-sharing

Apartheid was opposed by a number of liberation movements, the African National Congress (ANC), together with its principle ally, the South African Communist Party (SACP), foremost amongst them. These movements operated both inside the country and, with their banning in 1960, in exile. They were unbanned on 2 February 1990 in an historic speech to parliament by F.W. de Klerk, President of the National Party's apartheid government. This paved the way for the release of Nelson Mandela, a key ANC leader, and the commencement of official negotiations between the government and liberation movements. The main parties at the negotiating table, the National Party (NP) and the tri-partite alliance of the ANC, SACP and COSATU (the Congress of South African Trade Unions, a labour federation that had emerged in the 1980s), came with starkly differing approaches to ruling the country, and a history behind them of violent conflict. As van Zyl Slabbert (1998: 2) notes, the core of the apartheid ideology had been *"the belief, presented as fact, that people from different races, cultures, (and) ethnic groups could not be accommodated within the same political system"*. The ANC, on the other hand, believed that *"South Africa had such powerful centripetal political forces at work that all social, economic and political inequality had to be overcome in a political system of democratic centralism within a strong unitary nation-state"*.

In 1993, negotiations culminated in an agreement that, following the first democratic elections in April 1994, a Government of National Unity would assume power for five years. This government would rule under an interim constitution⁵ until a final constitution⁶ had been negotiated, providing the framework for fully-fledged elections to be held in 1999. This settlement demonstrated the extent to which the ANC's position had shifted away from 'majoritarianism' to one of 'power-sharing' in return for the NP's abdication of racially-determined power.

The notion of power-sharing - that is, a 'mixed government' in which the major parties rule jointly to prevent any one from imposing its will - is credited for lowering the political stakes at the time of the negotiations and facilitating a smooth transition (Lodge 1999; Welsh 1998). In the peaceful elections of April 1994 the ANC won a commanding majority of 63 percent of the vote for the National Assembly. As proportional representation was the foundation of the new electoral system, this entitled the ANC to fill two thirds of Parliament with its members. These members were selected from a prioritised list drawn up by the party's structures (in other words, they were not elected directly by constituencies). This majority also ensured Nelson Mandela's election as President, and entitled the ANC to an executive deputy presidency (filled by Thabo Mbeki) and 18 cabinet portfolios. The NP assumed the second deputy presidency and shared the remaining Cabinet portfolios with the Inkatha Freedom Party (Welsh 1998).

Within two years of the Government of National Unity's inception, however, rifts developed between the ANC and the NP. These arose out of differences in the understanding of how decision-making in the new government should be shared. Following the heightened political

⁵ 1993 Interim Constitution Act (No. 200 of 1993).

⁶ Constitution of the Republic of South Africa, Act No. 108 of 1996.

tensions around the local government elections in November 1995, and the failure of the NP to have the concept of power-sharing inserted into the final constitution, the NP withdrew to concentrate its efforts on opposition politics. The Government of National Unity remained an uneasy alliance until its term ended with the second democratic elections in June 1999.

3.2.2 The negotiated settlement and co-operative governance

Apart from power sharing, the negotiated settlement also provided for nine new provincial governments, each with a legislature and an executive elected by proportional representation and headed by a Premier. A quasi-federal arrangement allowed provincial governments to assume legislative and executive authority over certain key functions. This provision was born out of the fear of an over-powerful centre and, like power sharing, it helped to secure a smooth transition (Lodge 1999; Rapoo 1994; Welsh 1998). *“That the NP and IFP (Inkhata Freedom Party) could win majorities in the Western Cape and KwaZulu-Natal, respectively, served to mitigate the thumping defeat inflicted on them nationally”* (Welsh 1998: 57). In other words, institutional space was created at a sub-national level for parties that were beaten in the national elections to exercise some power, diffusing tensions between the supporters of opposing parties and promoting peace. However, the negotiators did not attend to the structure and facilitation of intergovernmental relations. This was partly because of a general lack of information on the way multi-tiered dispensations work in other parts of the world, and partly because the negotiation process was dominated by a political rather than practical debate on the merits of a federal versus a unitary structure. Consequently, the interim constitution made provision for three spheres of government – national, provincial and local – but *“contained no explicit reference to, or provision for, the institutionalisation, structuring or management of intergovernmental relations”* (de Villiers 1998: 167). Thus, the exact extent of provincial powers was left to the political process and the courts to resolve.

In 1994, Friedman and Atkinson predicted that provincial politicians would decide the evolution of provincial powers, rather than the proponents of federalism who had been prominent during the negotiations. Subsequent years showed this to be true to some degree. Provincial politicians gradually became more vocal about their right to influence policy formulation, while the ANC-dominated national government became more confident of its ability to achieve its goals through a decentralised system and thus more willing to countenance the devolution of power. There were tensions between provinces and central government concerning the slow pace of change, especially in the early years. Dissatisfaction was evident even in the ANC-dominated provinces where the principle of a unitary state was accepted in theory (Lodge 1999; Rapoo 1995). One of the reasons for this is that *“the ANC between 1990 and 1994 expanded its organised following very rapidly and in doing so incorporated a multitude of different local political cultures as well as contrasting styles of political leadership”* (Lodge 1999: 16), creating the potential for challenges to the central leadership. A particularly contentious issue was the fact that, in the first two years after the election, central government continued to determine the budgets - and hence the spending priorities - for each provincial department (Rapoo 1995; see also later chapters). But most conflict was resolved through political agreements, with only some being taken to the Constitutional Court. In a series of interviews with government officials, de Villiers (1998: 179) found that *“(t)he relationship between national departments and provinces is to a large extent characterised by a friendly and co-operative approach and style”*. Where there are problems these tend to be *“the consequence of the managerial style of some national departments rather than a fundamental problem of intergovernmental relations”*.

In contrast, however, a policy analyst interviewed by this project in 1998 concluded that centralising tendencies predominate over decentralising tendencies, and that the balance of power is consequently skewed more in favour of national government which tends to view

the other two spheres of government - provinces and local government - as spheres of 'implementation' rather 'representation'. In effect, provinces often have little latitude to apply national policies to their specific circumstances, this being true especially for the budgeting process which in any case is not conducive to effective consultation (see **Chapter 4** and **Chapter 5** for an elaboration of this point). These problems are confounded in provinces by party allegiances that result in divided loyalties. However, national government, like provincial governments, is constrained in its ability to assume control over decision-making because of a variety of capacity constraints. Hence the continuing instances of 'turf wars' between the different spheres of government.

With regard to who wields power *within* governments, the executives at national and provincial level have emerged predominant. The legislatures remain relatively weak for a number of reasons, including skills shortages, lack of experience and research support, lack of clearly defined roles and, due to the proportional representation system whereby members are elected by party structures as opposed to constituencies, a tendency to tow the party line (Krafchik and Weiner 1999; Lodge 1999; Mackay 1998). A number of Portfolio Committees, intended to advise Parliament and the civil service on sectoral issues, suffer from these weaknesses and are limited in their impact on decisions made by line departments (Rapoo *et al.* 1997; interview data; see also **Chapter 4**).

3.2.3 Other players with political influence

Apart from opposition parties, who else exerts influence over government in South Africa? As Lodge (1999) notes, the ANC's victory at the polls represented a broader victory for the anti-apartheid liberation movement as a whole. As intimated earlier the ANC's main partners in this movement were: the COSATU labour federation which, in 1994, had an affiliate strength of 1.2 million members; the South African National Civic Association, the civic movement which helped to embody the vigorous tradition of community politics which had been led by the United Democratic Front during the 1980s; and their old ally, the rapidly growing Communist Party which included many leading ANC figures.

The relationship between these groupings was never without tension, even in the run-up to the elections. In the early 1980s, one of the few legal vehicles for mobilisation of the oppressed was the newly created unions. Apart from guarding members' rights in the workplace, these unions, represented most prominently by COSATU, advanced the cause of the struggle in general, and participated in an integral way in the formulation of ANC policy once it was unbanned. As negotiations forced the ANC to accommodate the interests of political opponents and business alike, rifts began to emerge between itself and parts of the union membership. As discussed later, unions were responsible for reinforcing some of the principles key to the struggle, but potentially under threat by the accommodation of powerful apartheid interests, through the vehicle of the Reconstruction and Development Plan (RDP) which expressed the ANC's economic policy and development strategy at the time of going to the polls (see later). More recently, organised labour has accused the ANC of being persistently and unduly influenced by business and of excluding it from effective participation in policy-making, especially in relation to the government's macro-economic policy (see later; Lodge 1999).

Certainly, the climate for business – and international business in particular – is much more favourable than augured by calls in the late 1980s for widescale nationalisation of private enterprises. In explanation, Van Zyl Slabbert (1998: 7) notes that *"the drive toward democratisation and reforms towards a competitive market economy have become the two dominant trends over the last 20 years. These are the two primary export commodities from the consolidated democracies of the West and have had a profound impact on the political transitions and economic reforms of countries in Latin America, South East Asia, Central*

and Eastern Europe as well as Africa". Matisonn (1998: 17) describes how, for emerging leaders within the unbanned ANC, this general trend was reinforced both by immediate lessons learned from "*the mistakes of Africa, Eastern Europe and Latin America of relying too much on the state sector*", and by deeply-held values within the ANC which "*consistently nurtured tolerance and moderation*". More critical analysts, such as the controversial Australian journalist, John Pilger, characterise the negotiations in 1993 as a pact between the black elite and business, which had been meeting overseas since before the unbanning of the ANC, to share and consolidate power under the new regime (Pilger 1997). Whatever the motivations, as early as 1991 Nelson Mandela stated in a speech delivered in the USA that "*the private sector must and will play the central and decisive role in the struggle to achieve many of these (ANC) objectives ... The rates of economic growth we seek cannot be achieved without important inflows of foreign capital*" (Matisonn 1998: 16). In accepting this, "*they find themselves 'in tune' with the international environment and now face the challenge of making this ideology 'work' for the 'new South Africa'*" (Van Zyl Slabbert 1998: 9). Having to accommodate its former partners in the struggle, especially COSATU, in this new environment, the new government frequently finds itself accused by business of instituting labour practices hostile to its interests. However, Lodge (1999) makes the point that, in fact, both labour and business have fared relatively well under the new government.

In the health sector, as in the broader economy, the private sector has always been a powerful player and has shown itself adept at limiting government options for controlling its activities. Initially antagonised by calls from the progressive health movement in the late 1980s to nationalise private care (Centre for Health Policy 1990), the private sector warmed towards pre-election ANC health policy which envisaged a significant role for the private sector (African National Congress 1994a; Magennis 1994; interview data). This was especially the case for the medical schemes industry whose role, under the new scenarios, was more certain (interview data). As one interviewee commented, the medical schemes industry "*was a movement well-aligned - in the way it conducted its affairs, in the nature of its leadership, in its vision of its own future - ... to government thinking*". Private providers, especially the powerful hospital sector, were more cautious, seeing the potential for their activities to be curtailed through the expansion of public sector services (see, for example, Medical Association of South Africa 1994). The pharmaceutical industry, responsible for a large part of the cost-escalation in the private sector, was almost inevitably hostile towards the new government's attempts to control it.

The rapprochement between the public and private health sectors certainly reflected the general accommodation of private sector interests by the ANC in the early 1990s (Centre for Health Policy 1990), but it also grew out of international developments in health policy which emphasised the role of the state as a funder and regulator of health care but acknowledged the role of private providers in service delivery (de Beer and Broomberg 1990a; interview data). Dealing with the private sector remains a complex process for government, however, not least because the sector is rife with internal divisions, each interest group voicing its competing needs vociferously (interview data; see also **Chapters 7-8**). Yet despite the prominence of the private health sector in reform debates, the countervailing interests of the public sector remains significant within the new government's health policy formulations (see, for example, the prominence given to the RDP in the Department of Health's White Paper for the Transformation of the Health System in South Africa (Box 3.2)).

Box 3.2: The White Paper's contextualisation of health policy within the ideology of the RDP

'The RDP sets the framework whereby the health of all South African must reflect the wealth of the country and lays the foundation for a process of democratizing the State and society that will foster the empowerment of all citizens and promote gender equality. The second thrust of the RDP concerns building the economy. Poverty is widely recognised as a major determinant of the health status of individuals, households and communities, and gains in health will only be possible if the RDP's attack on poverty through economic development succeeds. The third component of the RDP is the development of human resources. Equipping individuals with the necessary knowledge to care for themselves will be a major step towards improving their health. No factor can be shown to be more important for a family's health than the educational status of women. Therefore the RDP's emphasis on women in the planning and implementation of human resource development is critical to the improvement of health. Finally within the RDP's focus on meeting basic needs the development and improvement of housing and services like water and sanitation, the environment, nutrition and health care represents its most direct attack on ill health. It follows that trends in health status during and following the implementation of the RDP will be amongst the most important indicators of the success of the entire programme. The Department of Health aims to ensure that the health sector succeeds in fulfilling this vital role in ensuring progress.'

Source: Republic of South Africa 1997: 11-12

In contrast to the for-profit private sector, the influence of the progressive professional associations and non-governmental organisations that featured so prominently in health policy development in the 1990s, has waned. One reason is that many former activists were incorporated into government following the 1994 elections (Lodge 1999; see also **Chapter 4**).

In answering the question then, who rules South Africa, Lodge (1999: 11) believes that "(a) political movement governs - and has real power ... to reshape political and economic life. The interests it represents are amorphous - the constituents of a social alliance: organised labour, black entrepreneurs, an emergent managerial class, rural poor, a multiracial intelligentsia informed by competing humanitarian and radical traditions. No one group is dominant nor is the likely ascendancy of any one of these certain. They struggle for influence in a relatively poor, middle-income, developing country on the margins of the international economy ...". This applies equally to the health sector as it does to the nation as a whole.

3.3 Administrative restructuring

3.3.1 The co-ordination of intergovernmental relations

With the implementation of the interim constitution in 1994, the debate around intergovernmental relations - and how they should be managed - was forced to become more pragmatic, focusing on the implementation rather than the theory of the new system of government. A number of bodies were set up to co-ordinate reform. First amongst these was the Commission on Provincial Government which facilitated the establishment of provincial government. Whilst the Commission achieved this purpose, it lacked the political credibility to propose mechanisms for managing intergovernmental relations. Political oversight by the national and provincial assemblies was also lacking, while the Senate, a new national body in which provincial interests could theoretically be aired, in practice contributed little. On the contrary, it tended to be perceived as adopting a national, as opposed to a provincial, agenda. In large part, co-ordination was thus left to various groupings of provincial and national office-bearers. The Intergovernmental Forum, where provincial premiers could meet with their national counterparts, played an instrumental role in the early years in facilitating intergovernmental relations. It set up more than twenty sectoral MINMECs, which included

the Ministers and the Members of Provincial Executive Committees (the equivalent of Ministers at a provincial level) for all the Schedule 4 functional areas in the final constitution (previously the Schedule 6 functional areas of the interim constitution). These are the areas where national and provincial governments have concurrent legislative powers, health being but one example. The MINMECs, together with their technical counterparts (committees composed of the Director Generals from different provinces), became the workhorses of intergovernmental relations (in the case of the health sector, the technical committee is known as the Provincial Health Restructuring Committee (PHRC)). In commenting on the setting up of all these structures, de Villiers (1998: 183) writes, *“(f)or a country that has no history of democratic provincial government, where the notion of inter-governmental relations was totally unknown until 1993, and where there was a background of suspicion of any form of federalism, one cannot but be struck by the pragmatism and sense of urgency of all those involved in establishing a myriad inter-governmental relations forums. Compared to other developing countries this is a remarkable achievement”*.

Yet the process had a number of shortcomings, one being that *“(u)p to now intergovernmental relations have been characterised by spontaneous and ad hoc developments, which has given rise to criticism of a lack of transparency and accountability”* (de Villiers 1998: 184). This was aggravated by the fact that no structures were set up or activated to monitor the functioning of intergovernmental co-ordination. For example, since 1994 none of the national Parliamentary Portfolio Committees has formally addressed intergovernmental issues or, in particular, scrutinised the degree to which provinces have in practice been allowed to exercise their theoretical powers. As a result of the lack of structured oversight, most intergovernmental bodies worked without any public scrutiny or political control, and bureaucrats became extremely powerful. While this reflects a world-wide tendency in intergovernmental relations, and whereas controlling all aspects of intergovernmental relations could stifle the creativity and flexibility of these relations, it is notable that appropriate checks and balances are absent (de Villiers 1998). An array of other problems also plagued intergovernmental relations and limited the capacity of the new administration to implement and co-ordinate change in its first years in office. Most of these problems related to a lack of clarity around the roles and responsibilities of different bodies or to capacity shortfalls in taking on and managing tasks appropriately (see Box 3.3).

Box 3.3: Some problems that plagued intergovernmental relations, 1994-1999

1. a lack of co-ordination of intergovernmental relations;
2. a lack of communication between different components of government;
3. a lack of clear briefs for some bodies regarding their role in intergovernmental relations, leading to a lack of action;
4. overlapping functions for some bodies, leading to confusion and rivalry;
5. lack of political credibility for some bodies, meaning that they are not used as channels for expressing provincial aspirations;
6. an ambivalent relationship of the Inkhata Freedom Party with some bodies, undermining their status and effectiveness;
7. limited capacity to carry out briefs;
8. an excessive number of meetings which overload representatives and keep them out of the office for extensive periods of time;
9. provincial delegates differing in status, especially when civil servants are asked to stand in for political representatives;
10. the tendency by national ministers to use some bodies as a route for informing, rather than consulting, on policy; and
11. practical difficulties, such as difficult communication by mail and telephone, and awkward travel arrangements, especially as meetings are held in different parts of the country.

Source: Adapted from de Villiers 1998; Presidential Review Commission 1998.

These sorts of problems led to significant changes to the final constitution so that now it “contains the most detailed directives and principles for intergovernmental relations of any constitution in the world” (de Villiers 1998: 168). One such change was the creation of a National Council of Provinces to replace the Senate (the Commission on Provincial Government was also replaced with the Advisory Council on Intergovernmental Relations). Its role is to represent and co-ordinate more effectively provincial interests in the national legislative process. The mandate of its representatives is formulated by the provincial legislatures and it has fairly wide authority, including participation in the amendment of the constitution, bills falling within the ambit of Schedule 4, bills falling outside Schedule 4, and bills that require a national over-ride over exclusive provincial powers. It includes representation (without voting rights) of local government. All in all, the National Council of Provinces has the potential to have a large impact on introducing provincial interests into debates, as well as controlling the various intergovernmental bodies (especially MINMECs), particularly if they are supported by more vigorous provincial portfolio committees. However, critics of the Council see it as an institution that will allow the ANC to dominate government through deploying its political control in a majority of the provinces, thereby ensuring uniformity in action (interview data). This line of influence is perhaps all the more easy because of the capacity constraints at the provincial level which prevent provincial administrations from making timeous and effective interventions at Council meetings.

Problems with managing intergovernmental relations can still be expected to persist over time, therefore. There is still dispute over whom should be responsible for formulating overall policy on intergovernmental relations - the National Council of Provinces, the Intergovernmental Forum or the Department for Constitutional Development. More generally, the fact that federalisation has had to occur through a process of decentralising a previously centralised government, rather than aggregating a set of previously independent units, means that “the actual decentralisation of powers to the provinces will not only take time but will also be characterised by a great deal of overlap of functions between the various levels of government” (de Villiers 1998: 168). In addition, the relative powers of national over provincial government, in terms of its constitutional right to overrule provincial legislation in the interests of national security, economic unity and minimum standards for service provision, still need to be teased out. There are also instances where executive authority remains highly centralised. The labour agreements made through the centralised and sectoral bargaining councils are a case in point: these agreements dictate important parameters - such as personnel grades, salaries, retrenchment packages and re-deployment procedures - which impact dramatically on provincial planning and budgeting processes (see also **Chapters 5 and 9**).

As yet, this discussion has not yet touched on the two remaining aspects of intergovernmental relations, namely the allocation of revenues and budgets under a quasi-federal system, and the emerging issue of the role of local government. The Financial and Fiscal Commission (FFC) was set up under the interim constitution, and continues under the final constitution. Its role is to advise all levels of government on financial and fiscal arrangements, including providing guidance on the formula used to divide up the budget between provinces. It is thus potentially an important player in the realm of budgeting and resource allocation but experience to date has shown that it has been less influential than expected (see also **Chapters 4 and 7**).

The issue of the role of local government - the third sphere of government - and its relationship with provincial and national levels of government, is likely to dominate intergovernmental relations in 1999 and beyond. The provisions made for local government in the constitution are significant. It allows for “a constitutionally entrenched, strong and autonomous local government level which has the potential to develop into powerful

government bodies as well as a collection of extremely influential policy implementation agencies for other government bodies, if it is in practice empowered with sufficient funds for these purposes” (Cloete 1998: 147). However, the reality is that many local authorities remain fairly weak and inexperienced in service delivery. What capacity does exist tends to still be racially fragmented. As Cloete (1998: 160) comments, “(t)he local government sector in South Africa still contains some of the most visible manifestations of apartheid, perhaps reflecting in the most cogent way the schizophrenic and dual nature of the apartheid society”.

In addition, the way in which local government will eventually function is still in the process of refinement, as is the specific issue of how these governments will be financed (Brijlal *et al.* 1997; Gilson *et al.* 1996). Cloete (1998: 146) notes that “(t)he task of local government transformation can be regarded as an even more complex one than that of regional and national restructuring, because of considerations like the large number of actors involved ... (T)he full model will probably still take years to be negotiated and finalised, because the local government system is intimately involved in the continuing political power struggle between national, regional and local political elites”. For example, one of the complex issues to which changes in the status of local government have given rise, is the need to create local authority boundaries which coincide in a coherent fashion with the districts used by service departments, such as health, for the delivery of decentralised services.

3.3.2 The transformation of the public service

The transformation of the public service, which gives effect to government’s policies, has occurred alongside political transformation and the re-organisation of levels of government. In 1994, the public service employed 1.2 million people and accounted for 54 percent of the total government budget, excluding interest on government debt. At its inception, therefore, “the new government faced the reform of a bloated public service which was sapping national resources and not delivering even the existing, racially biased services with anything approaching efficiency” (Sidloyi 1996: 140). This public service was managed according to wholly outdated principles, and suffered from the deficiencies characteristic of many bureaucracies in developing countries (Box 3.4; see also **Chapter 9**). Another feature of the South African public service is that effective control over training, appointment and promotion rested - and still rests - with a central government structure, the Commission for Administration, which was renamed the Public Service Commission in the interim constitution. This centralised control inhibits decision-making at the regional - and even facility - level.

Box 3.4: The characteristics of the bureaucracy inherited from the apartheid state

1. A rule-driven bureaucracy
2. Corruption and mismanagement of resources
3. Poor and outdated management
4. Unresponsiveness to citizen-consumers
5. A lack of operational (as opposed to financial) accountability
6. A lack of transparency
7. Inadequately trained staff
8. Poor labour relations
9. A de-skilled hierarchy of jobs

Source: Swilling and Woolridge 1996

The interim constitution allowed for the rationalisation of the public service through a variety of measures (Swilling and Woolridge 1996):

1. the amalgamation of the 11 separate apartheid administrations;
2. the creation of organisational structures for the new departments and administrations;
3. the absorption, transfer and placement of staff into posts created in the new organisational structures by the Public Service Commission;
4. downsizing through early retirements to create a leaner civil service as well as to create capacity for representivity achieved through affirmative action;
5. the institution of redundancy measures to deal with excess staff while maintaining fair labour practices (these measures essentially protected employees of the old regime from losing their jobs); and
6. the development of a policy framework on affirmative action and the filling of 11,000 posts to improve representivity.

In the 1994 to 1999 period, a number of policy documents - such as the White Paper on the Transformation of the Public Service (1995), the White Paper on Financial Management and Expenditure Budget Reform (1997) and the White Paper on Human Resource Management in the Public Service (1997) - were produced to effect public sector transformation. However, in 1996 Sidloyi (142) judged the earliest measures to have fallen short of achieving for the public service “*a fundamental change in its composition, a massive reorientation of principles and ethos, and a large-scale rationalisation programme*”. In 1998, the report of the Presidential Review Commission on the Reform and Transformation of the Public Service in South Africa (Presidential Review Commission 1998, section 7.2.1) concluded something similar, stating that “*the system of governance in the new Republic of South Africa is in a number of crucial respects not working well at this stage of the transition process*”.

Thus, the public service continues to struggle with its inherent weaknesses (Human and Strachan 1996; Lodge 1999; Monitor Company *et al.* 1996; Presidential Review Commission 1998). Problems are greatest in provinces which were disadvantaged by apartheid in terms of resources and which, after the elections, were faced with rapidly amalgamating the bureaucracies of former homelands, each with its own managerial style, and most of which lacked technical skills, management systems and professional integrity. Capacity problems include poor information systems which even now have difficulty identifying the number of employees within the bureaucracy, as well as the number and location of government facilities, let alone the number of legitimate beneficiaries for certain services (such as state pensions).

The new provincial structures also brought together competing political elites that still experience difficulties working with one another. Another dimension of the slow pace of change is the fact that bureaucrats from the old regime still operate within the new bureaucracy, through an arrangement under the interim constitution - known as the ‘Sunset Clause’ - that jobs would be protected, with voluntary severance being the only mechanism for removing unwanted staff. This has not affected the new government’s ability to appoint its own people into important policy-making positions (interview data) but does severely restrict its ability to reform the composition and distribution of personnel involved in service delivery (see **Chapters 7 and 9**). While many old-guard bureaucrats have accepted the change in government, some are apathetic towards change, and others may actively place obstacles in the path of reform (Human and Strachan 1996; Presidential Review Commission 1998). Some of this resistance may be a result of uncertainty about their roles and modes of operation within a fundamentally changed system (Presidential Review Commission 1998; interview data).

Overall, therefore, many of the delivery problems faced by provincial governments between 1994 and 1999 can be attributed to capacity deficits (Lodge 1999; see also **Chapter 9**). Box 3.5 uses the case of the government's Reconstruction and Development Programme to show how the nature of the public service interacted with other factors to slow delivery in this period.

Box 3.5: Reasons for slow delivery by the RDP of its development-oriented projects

1. a bureaucracy unable to transform into a change agent because the posts of apartheid civil servants are protected;
2. tensions between the RDP and the line departments over functions and resources, and a reluctance to implement inter-departmental co-ordination;
3. a shortage of personnel skilled in development planning and project management at both provincial and local levels of government;
4. complex tendering procedures unsuited to rapid delivery;
5. cumbersome procedures for approving budgets imposed by the Department of State Expenditure;
6. complex business planning requirements imposed by the RDP;
7. failure at all levels of government to put in place mechanisms for consulting with civil society;
8. a continuing failure by township residents to pay rent and service fees, thus depleting local authorities' resources for development; and
9. the tendency for departments to use RDP allocations as an additional source of funds, rather than to transform their existing programmes.

Sources: Kraak *et al.* 1996; Gottshalk 1998; Marais 1998

3.4 The new economic policy

3.4.1 Economic policy under apartheid

Despite having a level of output per person higher than every other country in sub-Saharan Africa, except Botswana and Gabon, South Africa faced economic problems under apartheid. Since 1980 its GDP increased on average by only 1.7 percent a year while its population grew by 2.5 percent (de Bruyn *et al.* 1998). One consequence of this slow growth was that very few new jobs were created and an increasing number of people earned their living in the so-called 'informal sector'. The resulting poverty is widely seen to be one of the most important, and lasting, consequences of apartheid (African National Congress 1994b).

One of the reasons for the poor economic situation was that international sanctions were imposed against South Africa in these years, limiting international investment and decreasing opportunities for trade. But in spite of slow economic growth, government expenditure rose, outpacing increases in total revenue from the mid-1980s (Fallon and da Silva 1994). By 1992/93, the year before the elections, the budget deficit was R27.4 billion⁷ or 7.8 percent of GDP (Department of Finance 1994). By 1997/98 interest payments on the debt accumulated to finance such deficits were, at 20 percent of the consolidated government budget, the second largest government expenditure after education (May 1998). Two-thirds of this debt was created after 1990 as a result of "*the unravelling of the apartheid state, in particular paying off the old civil and military services, together with the dynamic effects of paying interest on that growing debt*" (Duffy 1998: 6). The debt is unusual in that it is primarily domestically owned, which has led some critics of government economic policy in the late 1990s to suggest that there are more gentle ways to relieve this debt burden than presently proposed (Duffy 1998) (see later discussion of the 'GEAR' strategy).

⁷ In 1992/93, the exchange rate was approximately R3 = US\$1.

3.4.2 The Reconstruction and Development Programme

At the time of the first democratic elections, when the problem of debt servicing had not yet come to the fore, hopes were high that the apartheid bureaucracy could be transformed into a developmental state “*meeting the basic aspirations of the mass of the people*” (Kraak *et al.* 1996). Shortly before the elections, the ANC published its Reconstruction and Development Programme (RDP) which established its vision for the new society and, with an explicit commitment to redressing economic and social inequalities, defined priorities for all the major social sectors. Forty-one pages out of 147 addressed economic concerns (Lodge 1999): hence, in the absence of any other policy, the RDP came to serve as the clearest indication yet of the ANC’s economic intentions (Kraak *et al.* 1996).

The RDP’s first four drafts had been “*chiefly the product of policy expertise associated with the trade union movement*” (Lodge 1999: 4). This movement sought to address the gap which had emerged during the negotiations whereby “*(t)he political/ideological project of nation-building became paramount and supplanted - or at least overshadowed - the socio-economic features of the (apartheid) crisis*” (Marais 1998: 89-90). Further drafts came to represent more diverse interests, including the ANC, Communist Party, Mass Democratic Movement affiliates and a range of sectoral NGOs. Lodge (1999) notes that, as the RDP evolved, it moved away from its original predisposition for an extension of public ownership, a prescribed high wage economy and a central role for organised labour in policy formulation, all within a system where redistribution would be the main driver of economic growth. These sentiments were replaced with a sense that the public sector might need to be reduced, property rights require legal protection, and South African manufacturing need exposure to international competition. The changing nature of the RDP over the period of its evolution perhaps accounts for the different ways in which it is interpreted by different groupings in society (see Table 3.6).

Table 3.6: What does the RDP ‘mean’?	
Social grouping	The essential characteristics of the RDP
The ‘left’, including the more radical elements of the liberation movements	<ul style="list-style-type: none"> • redistribution as a central characteristic of government activity • economic reconstruction along a new growth path directed at ‘inward development’ • the state as the co-ordinator of development • development as a people-centred and people-driven process
The ‘right’, including business and the more conservative elements of the ANC	<ul style="list-style-type: none"> • development as a process which depends on a partnership between the state and private enterprise • a thinner, more efficient state • an internationally competitive economy • a better educated and more productive workforce
Popular voices	<ul style="list-style-type: none"> • the provision of benefits and opportunities - a better living environment, improved services, improved life chances
Source: Adapted from Lodge 1999	

In his inaugural speech, President Mandela launched the RDP by announcing a number of high-profile Presidential Lead Projects which received special RDP budgets and which were intended to address some of the critical socio-economic shortcomings of the apartheid system (a number of these projects were located within the Department of Health). The RDP was able to achieve some re-allocation of resources and services, but political complexities and the bureaucratic shortcomings of provincial governments, made the implementation of projects very difficult (Kraak *et al.* 1996; Lodge 1999; Marais 1998) (see Box 3.5). In addition, the aspirations of the RDP to involve civil society in decision-making went largely unfulfilled, due to the lack of mechanisms to involve community organisations, capacity

problems within these organisations, and the limited involvement of NGOs who frequently have the appropriate experience to identify needs (Rapoo 1994; Lodge 1999; interview data).

3.4.3 GEAR

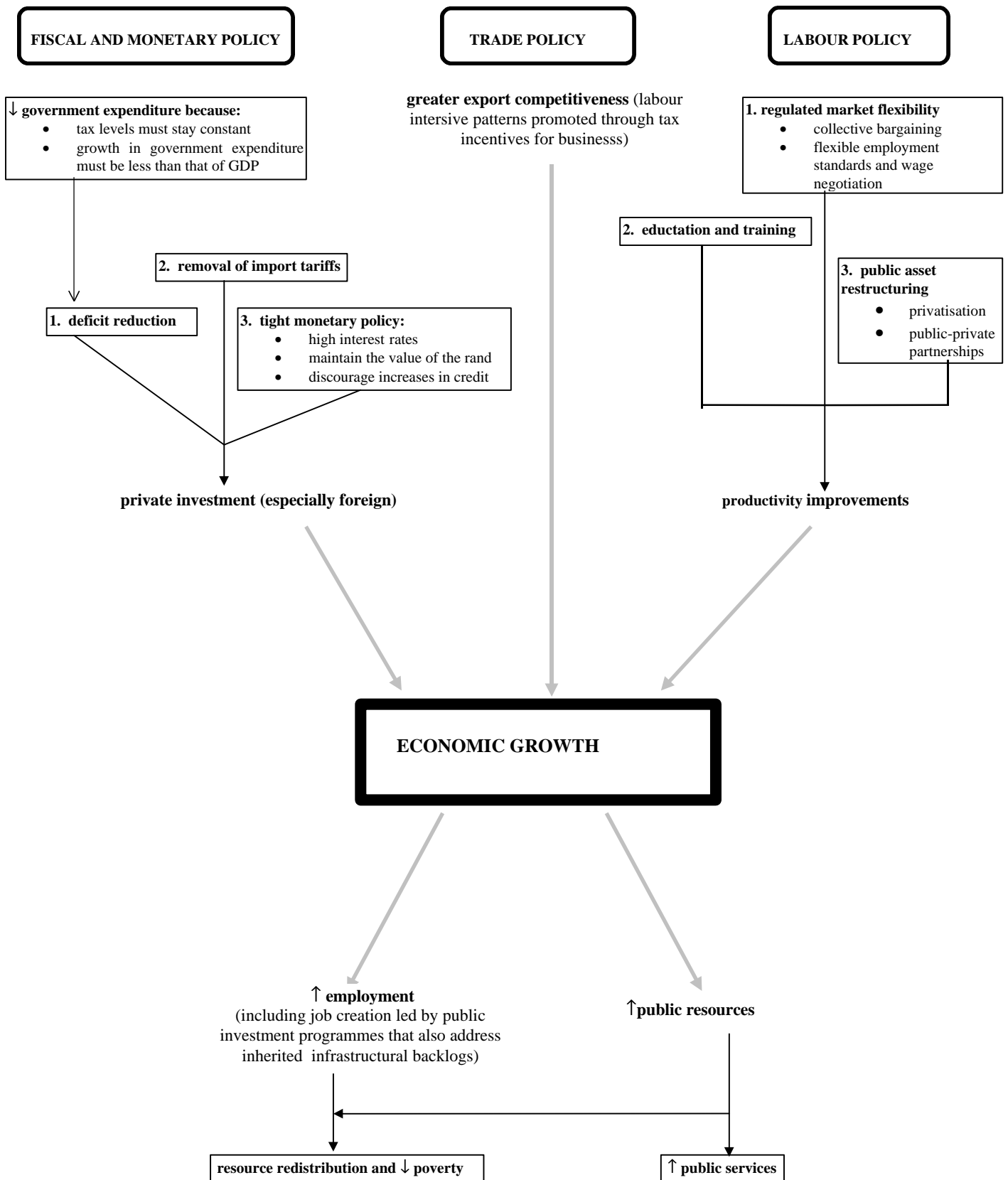
In 1996, the RDP was overtaken by further development of economic policy. In June of that year, the Department of Finance announced a new macro-economic strategy that became known as GEAR (the Growth, Employment and Redistribution strategy). This replaced the RDP as government's key policy platform although the government was at pains to explain that the RDP had not been abandoned, but had simply been internalised by line departments. Economic growth was the fundamental tenet of GEAR that pinned its achievement on three main strategies: the promotion of private (particularly foreign) investment; the encouragement of export competitiveness; and the achievement of productivity improvements (Department of Finance 1996; Gilson and McIntyre 2000).

Figure 3.2 shows diagrammatically how these objectives were to be achieved. Reducing the deficit from 5.7 percent of GDP in 1996 to 3 percent in 2000 was seen as central to improving business confidence and encouraging private investment. GEAR also argued that the tax to GDP ratio should be reduced from 26 to 25 percent, and that government spending should increase at a slower rate than growth in the overall economy, thereby requiring public spending to be strictly controlled. Other policies to promote investment included tight monetary policy (using high interest rates to keep inflation low, maintaining the value of the Rand, and discouraging increases in credit availability) and the removal of import tariffs and exchange controls in order to encourage foreign investment in particular. To complement these policies, trade policy was directed at ensuring export-led growth, with labour intensive patterns of production to be promoted through tax incentives for business. A separate package of labour policies also supported the development of regulated labour market flexibility and addressed the workplace inequities of the past.

Within this overall strategy, GEAR saw job creation resulting from economic growth as the main route for the redistribution of resources. Job creation would be led by labour-intensive public investment programmes that would also tackle the inherited backlogs in public infrastructure (energy, water supply and sanitation). As Heintz and Jardine (1998: 17) note, *"(t)he logic of GEAR is straightforward: as unemployment drops, poverty will gradually disappear. In addition, economic growth, once it happens, will also generate additional public resources which can then be used to provide public services and poverty relief. The document argues that reducing government spending in order to bring down the deficit will actually pave the way for increased spending in the future, made possible by rapid economic growth"*.

GEAR was thus a far cry from the policy of nationalisation that had been closely associated with the ANC in the early 1990s. What accounted for this dramatic shift? Van Zyl Slabbert (1998) notes that the international drive for democratisation in South Africa, which had culminated in the negotiated settlement of 1994, was followed by irresistible pressure from Western democracies for economic reforms towards a competitive market economy. Matisonn (1998) also argues that the views of ANC leaders were deeply affected by the failures of state-controlled economies in Africa and the former Soviet Union. Harsher critics attribute the final shape of GEAR to the pre-eminent influence of powerful elites, both at home and abroad. For example, Marais (1998: 147) believes that GEAR shows how, over time, *"the ANC government's economic policy had acquired an overt class character, and was unabashedly geared to service the respective prerogatives of national and international capital and the aspirations of the emerging black bourgeoisie, perhaps above all - at the expense of the impoverished majority's hopes for a less iniquitous social and economic order"*.

Figure 3.2: The mechanisms through which GEAR intends to achieve its objectives



Given the controversy surrounding GEAR, what do recent trends have to say about its impact on the plight of the poor? Although it is still too early to judge GEAR's success, the initial signs concerning economic growth and job creation are not encouraging. Growth rates in the late 1990s were slower than projected and unemployment continued to rise after GEAR's introduction (Gilson and McIntyre 2000). Heintz and Marais (1998) argue, amongst others, that GEAR particularly ignored the fundamental need to transform the economic structures, particularly the segmented labour market, inherited from the apartheid era. The most critical constraints on its potential to create jobs and raise the income levels for the poor are identified as its emphasis on the role of private investment and on export promotion, and its promotion of wage restraint and a flexible job market (Adelzadeh 1996; Budlender 1997; Maganya 1996; Marais 1997; May 1998).

Gilson and McIntyre (2000) conclude that while debates over GEAR's contribution to poverty alleviation will continue until empirical data at a household level become available, there are signals that GEAR may fail to tackle the underlying causes of poverty and health inequity in South Africa. However, as stock market crises in emerging markets around the world in the late 1990s began to jeopardise the achievement of GEAR's growth targets, the government also began to review aspects of GEAR. It is not yet clear what form these revisions will take.

In terms of GEAR's impact on government funding, initial evidence suggests that the government has been able to translate its commitment to redistribution into reality. In its first few years of office the government has increased levels of public spending on social services whilst decreasing spending on defence and economic services (such as energy, agriculture and fishing) (de Bruyn *et al.* 1998). However, commentators such as Gottshalk (1998) doubt whether these trends will continue. **Chapters 5 and 7** consider further the trends in public health care spending and their relevance to public health care provision in South Africa.

3.5 New health structures and policies

The first major activity of the new health policy-makers and managers who came into office in 1994 was the re-organisation of the fragmented public health sector of apartheid into a unitary system. Between 1994 and 1997, the 7,086 original posts in the national Department of Health (DOH) were reduced by 76 percent to 1,694 (Personal communication with Prof. William Pick, Department of Community Health, University of the Witwatersrand). The new, streamlined national DOH was then reconfigured, even whilst entirely new Departments of Health were set up in the nine provinces. At the same time, in accordance with the constitution and the evolution of inter-governmental relations in general, certain powers were devolved to the provincial Departments of Health. In fact much of the operational decision-making in health care delivery was decentralised to the provincial level, with the national DOH retaining only the responsibility for national policy making and the development of norms and standards by which to ensure equitable and affordable health care provision across the provinces. The newly powerful provincial departments now determine subsidies to local authorities and provide hospital services, comprehensive services in the former homelands and curative primary level care in other areas of the country.

By way of contrast, however, although the establishment of a District Health System was identified as a key policy of the new government (Department of Health/ Health Policy Co-ordinating Unit 1995), the further decentralisation of responsibilities to the district level progressed very slowly over its first term. One important reason was that the demarcation of health districts occurred at the same time that new local authority boundaries were being negotiated under the terms of the constitution (see discussion above). While the health sector, with its focus on integrated service delivery, proposed 180 districts, the local government

sector, with its more political concerns, proposed 843 (Ntsaluba 1998). Although local government is constitutionally responsible for delivering 'municipal health services', the difficulties of devolving authority to this level include the broader lack of clarity on the respective roles of the different spheres of government, specific uncertainty over what health services will be provided by local government and weak capacity at the local government level (Gilson *et al.* 1996).

The second primary task of the new health policy-makers and managers was the development of a national health policy statement, and the strategic planning and legislative processes necessary to translate its principles into practice. This statement was published in 1997, after an uneven process of consultation, as The White Paper for the Transformation of the Health System in South Africa (Republic of South Africa 1997). It put forward a comprehensive vision and strategic plan for the public health system, touching on all its aspects although largely failing to deal with the private sector (see Table 3.7). Envisaging a single, unifying health system that co-ordinated the efforts of the public, for-profit private and NGO sectors in the interests of promoting equity, it emphasised the role of the district health system as the key vehicle through which health care would be delivered in accordance with the PHC approach.

Table 3.7: Key elements of the new government's main health policy statement		
Element	Characteristics under the previous regime	Characteristics of the new policy
Health policy formulation	<ul style="list-style-type: none"> racially divided a focus on diseases hospital and urban bias 	<ul style="list-style-type: none"> attends to the needs of all South Africans, especially the most vulnerable comprehensive PHC based proposes a Charter of Patients' rights
Management	<ul style="list-style-type: none"> highly centralised bureaucratic 	<ul style="list-style-type: none"> decentralised participatory
Organisation	<ul style="list-style-type: none"> fragmented and ethnic-based public and private sectors acting independently 	<ul style="list-style-type: none"> single national health department focusing on policy and setting of norms and standards nine provincial departments a major shift to establish functional districts better co-ordination between the public and private sectors within a single national health system
Financing mechanisms	<ul style="list-style-type: none"> racially divided and inequitable private sector characterised by unsustainable cost escalation and perverse incentives driving the delivery side 	<ul style="list-style-type: none"> equity driving consideration in budgetary allocation aims at promoting efficiency
Drug policy	<ul style="list-style-type: none"> irrational prescribing patterns doctors dispensing for profit differential pricing between state and private sector 	<ul style="list-style-type: none"> essential drugs programme greater use of generics transparent pricing with single exit price no mark-up on drugs by professionals, only a professional fee aims overall to reduce the cost of drugs
Human resource development	<ul style="list-style-type: none"> ad hoc racial compartmentalised between professions institutional focus 	<ul style="list-style-type: none"> planned facilitates entry of students from disadvantaged backgrounds promotes a multidisciplinary approach community focus
Source: Ntsaluba 1998		

By 1999, however, the government had not passed through parliament the National Health Bill which, building on the White Paper, will define the powers and functions of national, provincial and district health authorities. Nonetheless, the new health officials had sought to undertake a radical overhaul of the inequitable and inefficient health system through a very wide programme of health policy change. Although specific health care financing reforms are discussed in more detail in the remaining chapters, Table 3.8 summarises the diverse set of other actions implemented between 1994 and 1999. This programme of change and its primary champion, the Minister of Health in the 1994-99 period, were both lauded and criticised – but could certainly not be ignored (see **Chapter 4**). Policies that generated particular controversy included the 1996 Termination of Pregnancy Act, legislation to reduce the cost of drugs through parallel importing, community service for newly qualified doctors and proposed legislation to substantially control tobacco advertising.

Table 3.8: Health policy reforms 1994-99	
Reform	Brief description
<i>Programmatic changes</i>	
Immunisation	A national polio campaign was conducted in 1995, and Hepatitis B vaccine was included in the range of vaccines provided by the public sector in the same year. A national immunisation campaign was launched in 1996 and repeated in 1997, focussing on polio and measles.
Nutrition	In 1994, a school-feeding programme was identified as a Presidential Lead Project and implemented nation-wide. The Department of Health also launched an Integrated Nutrition Strategy.
Reproductive health care	The constitution stipulates the right to access to reproductive health care. Consequently, reproductive health services have been expanded and the termination of pregnancy was legalised in 1996.
HIV/AIDS	A national AIDS review in 1996 found that, despite increasing budgetary allocations for the control of HIV/AIDS, successes were limited. A new programme entitled 'Beyond Awareness', focusing on behavioural change, was launched in 1998.
Tuberculosis	A national tuberculosis review was conducted in 1996, following which the Direct Observed Treatment Short Course (DOTS) was implemented, together with a new monitoring system.
<i>Legislation</i>	
Affordable, accessible and safe drugs	A National Drug Policy was launched in 1996 that addressed, amongst other things, the restructuring of the procurement and distribution system and the reduction of drug costs. An Essential Drugs List (EDL) was also published. A further set of reforms - the legalisation of parallel importing to allow the procurement of cheaper drugs, and generic substitution – were stalled in their progress through parliament by opposition from the private sector.
Termination of pregnancy	The termination of pregnancy was legalised in 1996.
Statutory councils	The Acts governing the statutory councils that fall under the DOH have been amended.
Tobacco control	New legislation around the advertisement of cigarettes was introduced in 1995. Further limitations on the tobacco industry were introduced into parliament in 1998/9.
<i>Other initiatives</i>	
Facilities audit	An audit of all hospital facilities was conducted in 1996 and found that a third of the value of all hospitals would need to be replaced, at the cost of R8 billion over the next 8 to 10 years.
Clinic-building programme	This was another Presidential Lead Project. Between October 1995 and mid-1998, 400 clinics were built and 152 extended. Approximately 4750 new primary health care posts were created in the first 1000 days (but not necessarily filled).
Health information systems	Efforts to establish a National Health Information System were slow in being implemented. Provinces are now establishing their own systems fairly independently.
Community service for medical graduates	From July 1998, compulsory community service was introduced for all newly qualified doctors.
Reforms in other sectors which have a health impact	A range of other projects under the RDP addressed health status in disadvantaged communities, most important of which were the provision of safe water and the electrification of houses in poor communities.
Source: Adapted from Ntsaluba 1998	

3.5 Conclusion

This chapter has described the broad context within which reform took place during the first term of office of the first democratically elected government of South Africa. Van Zyl Slabbert (1998) concludes that, while the slow implementation of certain reforms and the erosion of some of the principles that carried the ANC into the 1994 election have disillusioned some, progress has still been substantial. He notes (p.15) the continuing commitment to constitutional government and progressive democratisation of the country, and argues that “*(c)ontrary to popular perception, the new regime’s apparent ambivalence and paralysis does not arise from doing nothing, but trying to do too much*”. In the health sector, most commentators would agree that “*the majority of South Africans have better health care now than they did five years ago*” (Price 1999: 28), whilst acknowledging a number of limitations to what has been achieved.

From this chapter’s portrayal of the context within which reform - and health financing reform in particular – took place, five potential influences over the way reform evolved can be identified and are assessed further in later chapters.

First, the ‘post-apartheid transformation’ required a complete re-conceptualisation and reorganisation of the state and its relationship with society. In particular, the unification of previous administrations into a single bureaucracy, and the restructuring of government into a quasi-federal arrangement, was an enormous and complex task. Whilst undergoing structural change, vast racial and socio-economic inequities created enormous pressure on the new government to implement equity-oriented policies as speedily as possible. As almost every aspect of life in South Africa was in a state of transition and uncertainty, the opportunities to prioritise needs and plan the implementation of new policies adequately were probably limited. (See **Chapters 7 and 9**).

Second, the resources available to effect change were limited both by previous patterns of underdevelopment as well as new economic policies that sought to limit government spending and keep taxation levels low. This constraint on financial resources was accompanied by strictures on human resource redeployment and upward pressure on salaries through central bargaining arrangements. These limitations on resource mobilisation may have affected the opportunities for resource re-allocation between provinces, and between the hospital and PHC sectors, especially in the face of a rampant HIV epidemic which threatens to escalate the costs of health care dramatically (see **Chapters 5, 7 and 9**).

Third, the inequitable and unsustainable patterns of health care delivery inherent in the apartheid health care system provided an enormous challenge to the new government and are unlikely to have been easy to tackle (see **Chapters 5 and 6**).

Fourth, the new government catapulted inexperienced individuals from the liberation movements into positions of power. There they were confronted with an outmoded, inefficient and rule-bound bureaucracy subject to contradictory decentralising and centralising processes. These factors are likely to have constrained the capacity of the new government to implement transformation (see **Chapters 7 and 9**).

Fifth, the emergence of new patterns of intergovernmental relations around budgeting, for example, and the special place afforded the private sector through the negotiation process, introduced a variety of important players into the process of policy formulation after 1994.

Some of these actors are likely to have had a significant influence over policy development, and so also to have shaped its impact (see **Chapters 7 and 8**).

The overall aims of the project were to:

- strengthen the implementation of critical financing reforms in South Africa and Zambia;
- deepen international understanding of the factors facilitating and constraining the selected reforms' contribution to the broad performance goals of equity and health system sustainability.

Within the South African country study, the specific objectives were to:

- document the evolution of specific health care financing reforms in relation to (a) design, (b) steps in policy formulation and (c) initial implementation, as well as the linkages between individual reforms and between financing reforms and parallel institutional change;
- analyse retrospectively the critical factors facilitating and constraining the development and initial implementation of selected reforms;
- critically appraise the selected reforms' potential, or where possible, actual, contribution to the broad performance goals of equity and health system sustainability.

1.3 Areas of focus

Factors facilitating or constraining the development and implementation of health care financing reforms

A review of the few existing analyses of health reform experience was undertaken as a first step in this project (Gilson 1997b). It confirmed that the way in which health care financing reforms evolve is as likely to have a critical influence over the changes they generate, as the specific design of any reform.

Specific factors that have been found to influence the pattern, pace and impact of reform include:

- the importance of actors or stakeholders and their potential to block reforms - which is itself tied to the balance of power between different actors, often rooted in, and shaped by, conflict over the values and goals underlying reforms;
- the potential of reforms to alter the balance of power between actors as a result of the introduction of new or changed incentive structures;
- the strategies of policy development and implementation, including the differing contributions of incremental and radical implementation strategies in relation to different contexts – such as the potential of speedy implementation during a 'window of opportunity' to deliver change, but also the importance of building consensus and support for change through an incremental process;
- the mechanisms used in policy development as strategies for building consensus, legitimising reforms or even for deliberately delaying change (such as formal committees of inquiry);
- the importance of organisational capacity to successful reform - including both the formal skills and procedures within and between organisations, information and other resource availability and the informal social networks that promote common working practices and support achievement of organisational goals;
- the underlying contextual factors that shape the values underlying reforms and actors' behaviour, as well as determining the nature of selected reform proposals.

In general, Walt and Gilson (1994) suggest that these different factors can be categorised as four groups - factors of context, of the processes of policy formulation and implementation, of actors and of policy content or design. The term 'process' in this instance encompasses the steps in any

process of policy change (i.e. agenda-setting, design development, implementation and evaluation) and their timing, the strategies used within these steps to, for example, build legitimacy, consensus or capacity, as well as the specific mechanisms or bodies established to take forward any of the steps.

Features of reform design that influence impacts

Additional review of experience in implementing specific financing reforms further illustrates the two ways in which the design of any reform can influence the degree and nature of change achieved by the reform, that is, its impact. First, design details shape actors' responses to the reform – perhaps generating support or creating opposition. Second, through their influence over provider and user behaviour, the design details directly determine the equity and efficiency impacts of the reforms, as well as their sustainability. The design features of importance, by reform type, include:

(a) for resource mobilisation reforms e.g. user fees, pre-payment or social health insurance (Doherty 1997a; Gilson 1997a; Lake 1997):

- the fee or premium levels;
- the services for which fees are introduced or which are covered through pre-payment or social health insurance;
- the degree and range of exemption mechanisms within user fee systems, or the extent of risk sharing achieved through pre-payment and social health insurance;
- the mechanisms for using revenue use.

(b) for resource allocation mechanisms (Doherty 1997b):

- the criteria used to weight populations for need;
- the inclusion of 'special allocations' within formulae;
- the link between formulae components and the budget structure.

Past experience also hints at the potential influence of introducing financing changes singly or in combination, over their impact. Cost recovery mechanisms are, for example, commonly introduced without consideration of the complementary resource re-allocation mechanisms which are important in preventing the geographical inequities that could otherwise result from revenue retention at local levels. At the same time, the resource mobilisation potential of such mechanisms is likely to be enhanced by their linkage to pre-payment and other insurance mechanisms – especially at hospital level (Gilson 1997a).

In addition, the success of financing reforms seems to require implementation of a complementary package of institutional changes. Such changes include:

- the development of accounting and management capacities;
- decentralisation of revenue use control;
- quality of care improvements;
- re-designed information systems;
- effective community involvement in the design and management of financing schemes;
- the design of exemption mechanisms which target those unable to pay;
- stronger personnel recruitment and promotion practices.

Many analysts suggest that there is, for example, an important synergy between financing reforms and decentralisation of decision-making authority. This is tied, firstly, to the understanding that decentralisation can develop the managerial capacity required to allow effective implementation of new reforms. Bringing management closer to the population will allow the appropriate and efficient use of revenues raised through new resource mobilisation initiatives. Secondly, however, real decentralisation of authority may itself require financing reforms to mobilise or allocate resources to newly established decision-making bodies (Gilson *et al.* 1994). Effective implementation of financing reforms is likely, therefore, to require consideration of what responsibilities to decentralise, to whom and when. This 'sequencing' of reform implementation, the phased introduction of different changes over time and in recognition of their relevance to each other, is increasingly seen as an important element of successful reform (Leighton 1996). Whilst there are concerns about the dangers of initiating too much change at one time, some suggest that a comprehensive approach to reform will be more effective than piecemeal change (Gilson and Mills 1996; Mogedal *et al.* 1995).

Key implications for the project

Existing experience with health financing reform emphasises the importance of initiating early evaluation in order to guide, and fine-tune, the further development and implementation of these reforms. Whilst such evaluation should seek to measure the change achieved through reform (that is, their impacts), it is at least equally important that it specifically explores the factors that influence the nature and extent of change achieved. In other words, it is important to consider how the actors involved in the processes of design and implementation, as well as the design and the institutional context of any reform, shapes its impact. Such analysis can inform national and international policy-makers about how to manage processes of change more effectively and so enhance the extent of change achieved through reform.

Given the difficulty of disentangling the various factors influencing reforms, there is also growing recognition of the need for new evaluation approaches (Janovsky and Cassels 1996). The experience of undertaking a comprehensive assessment of financing reform can, thus, contribute to the development of approaches to explore the processes and context of policy-making and implementation, and by which to understand the less readily quantifiable impacts of reform.

1.4 Relevance of study to South Africa

The election of the first democratic government in South Africa in 1994 heralded an unprecedented wave of policy reform and institutional change across all sectors of government, including the health sector. 'Transformation' is the major imperative of the new South African government as it seeks to redress the apartheid legacy of poverty and inequality. In the health sector, the scale of the inherited inequities, which cut across the public/private divide of the health care system as well as geographical areas and population groups, pointed to the need for major structural re-organisation.

This evaluation of specific health care financing reforms in South Africa thus provides three opportunities. First, it allows investigation of these reforms as instruments for achieving health policy goals in South Africa. Second, it provides a window through which to understand the factors influencing the process of policy change in the newly democratic South Africa. Third, and finally, it provides inputs to the continuing development and implementation of actions to tackle the apartheid legacy in the health sector. Evaluation, especially the kind undertaken in this study, must be a critical element of the continuing current efforts to 'deliver' real changes in the health care available to all members of the population.

CHAPTER TWO

STUDY FOCUS AND APPROACH

2.1 Period and reforms of focus

The study's main period of focus was 1994-99, that is the term of the first democratic government of South Africa. However, the last six months of this period (roughly November 1998-April 1999) were less closely investigated because it was also the period during which the initial analyses of the study were being undertaken. The study also looked fairly closely at policy debates in the pre-1994 era (from around 1988), in order to understand the roots of post-1994 policy development.

Table 2.1 outlines both the health care financing reforms that have been the focus of this evaluation in South Africa and the parallel, institutional reforms that were considered.

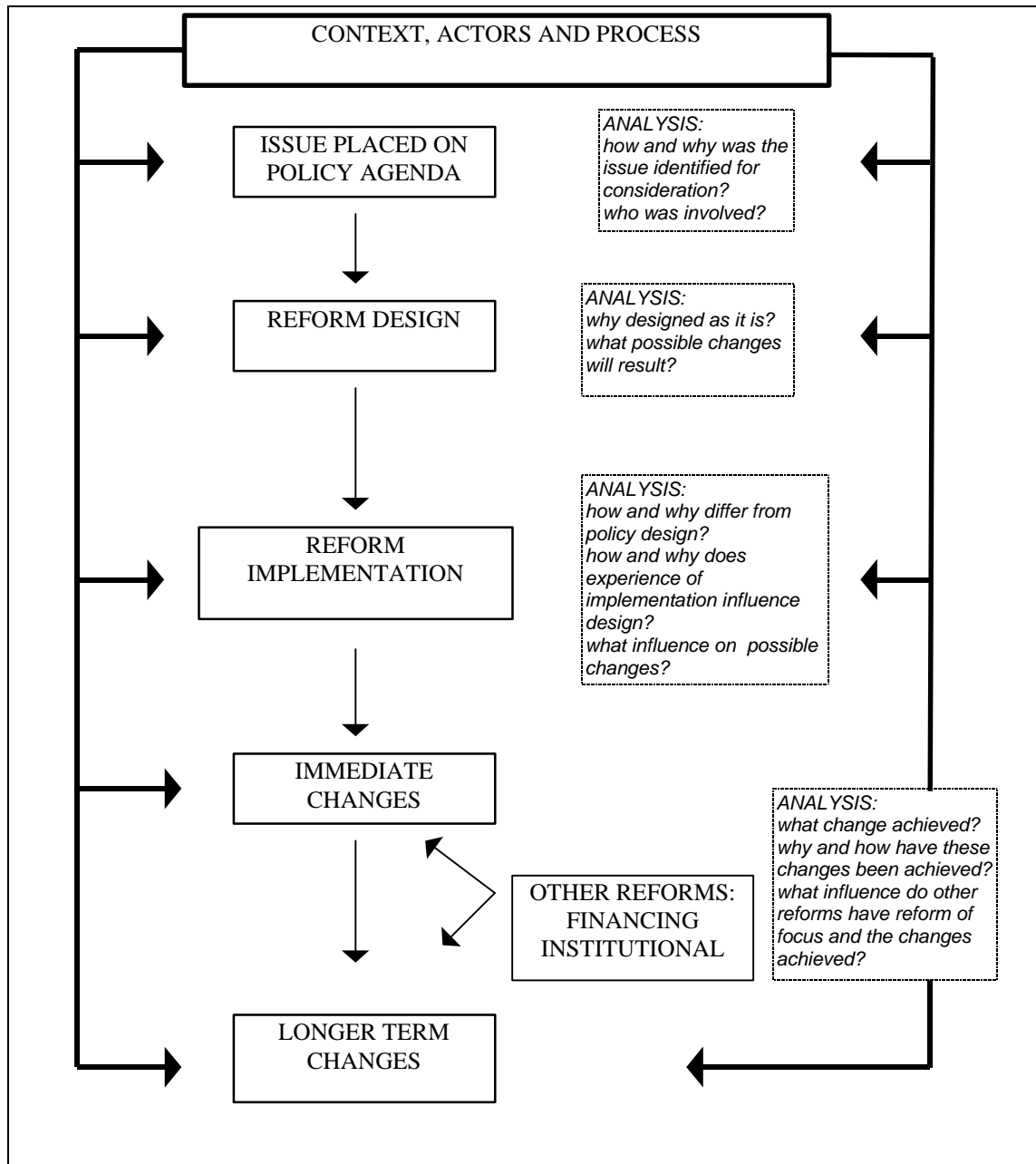
Table 2.1: Reforms of focus in South Africa	
<i>type of reform</i>	<i>Specific reform</i>
<i>resource mobilisation</i>	Removal of user fees for publicly-provided care for pregnant and nursing women and children under six (Free Care 1), and removal of user fees for primary care (Free Care 2)
	re-structuring of public hospital fees
	Development of proposals for social health insurance
<i>resource allocation</i>	development of inter-provincial resource re-allocation formulae
<i>parallel, institutional reforms</i>	creation of provinces within semi-federal state
	proposals to strengthen hospital management
	development of district health system

2.2 Conceptual framework and research questions

The framework developed to guide the overall project is summarised in Figure 2.1. For conceptual clarification the framework posits a linear process of policy change moving from agenda-setting around a reform of focus, to reform design and then through implementation to the achievement of immediate and longer-term changes. The framework's primary focus, however, is on detailed investigation at each step of what factors influence this apparently linear process and so, ultimately, shape the nature and extent of change achieved by the reform.

In investigating these factors, the framework points to the need to consider who or what causes an issue to be placed on the policy agenda and why specific reforms are designed in particular ways. Acknowledging that the nature of the reform is likely to change in unexpected ways through the process of implementation, it also allows such changes to themselves become a focus of enquiry.

Figure 2.1: The SAZA study's conceptual framework



Drawing on the policy analysis approach of Walt and Gilson (1994), the framework suggests that the factors influencing each of the steps in the reform process can be categorised into four broad groups:

1. factors of *context* (derived from Leichter 1979):
 - situational factors i.e. the specific conditions of a moment in history that impact on the policy changes of focus;
 - structural factors i.e. the relatively unchanging circumstances of the society and polity such as the structure of the economy and the political system;
 - cultural factors i.e. the values and commitments of society as a whole and groups within it;
 - exogenous factors i.e. the events and values outside any one country or system that influence it;
2. factors concerning *actors*:
 - who they are as well as their interests, values and roles in relation to the developing and implementing the reforms of focus;
3. factors of *process*:
 - the way in which the policies of focus are identified, formulated and implemented, including issues of consultation, timing and phasing;
4. factors of *content*:
 - the nature and design of the specific reform of focus;
 - the interaction between the financing reforms of focus and the interaction between these reforms and parallel institutional changes.

Overall, therefore, the conceptual framework highlights two sets of broad research questions (also translated into more detailed questions in Annex 2.1):

1. Analysing impact:

- what are the immediate and longer-term consequences of the reform?
- does it achieve its objectives?
- what are the potential consequences of the reform given its design? is it likely to achieve its objectives?

2. Understanding the 'policy process' as an influence over impact:

- how do factors of context, actors, process and content influence impact through the reform design and implementation process?
 - what factors determine the particular nature of the design of each reform and of the 'package' of reforms being taken forward within a country?
 - does the practice of implementation influence the design of the reform? how?
 - what factors explain how implementation practice differs from policy design?
 - what factors explain the (potential) immediate and longer-term consequences of the reform?
 - what influence do other financing and parallel institutional reforms have over the reform and its consequences?

2.3 Overview of research strategy and methods

2.3.1 Overall research strategy

Table 2.2 provides details of the key activities in each main phase of the research.

Table 2.2: Summary of research strategy		
Phase	Key foci	Data collection/analysis methods
1	<ul style="list-style-type: none"> delineation of key elements of reform context description of chronology of key events in reform evolution identification of key actors involved in reforms detailed description of the design of the reforms of focus 	<p><i>Data collection:</i></p> <ul style="list-style-type: none"> capture of researchers' own knowledge review of key policy documents and evaluation reports key informant interviews with informed and accessible policy-makers and policy analysts <p><i>Data analysis through:</i></p> <ul style="list-style-type: none"> development of 'timelines' for each reform of focus initial 'policy characteristics' analysis
2	<ul style="list-style-type: none"> detailed analysis of the factors facilitating and constraining the reforms of focus assessment of the potential or, where relevant, actual impact of reforms 	<p><i>Data collection:</i></p> <ul style="list-style-type: none"> key informant interviews with policy-makers and managers central to reforms generally or to specific reforms review of parliamentary debates and other documentary material from parliament media analysis collection of secondary data for impact analysis <p><i>Data analysis:</i></p> <ul style="list-style-type: none"> further use of selected policy analysis techniques e.g. stakeholder analysis, policy mapping techniques impact analysis through use of secondary data
3	<ul style="list-style-type: none"> draft and finalise country reports 	<p><i>Data collection and analysis:</i></p> <ul style="list-style-type: none"> the process of writing a draft report entailed further analysis and then elicited further information through the review process, information that was in turn fed back into report finalisation

An overview of key issues concerning the reforms of focus was undertaken in Phase 1, providing a foundation for the detailed analysis undertaken in Phase 2. The information collected in this phase also allowed the analytical questions guiding analysis to be revised and fine-tuned. Phase 2 then involved more detailed analysis of the key areas of focus, using a wider range of data analysis techniques and approaches and leading to a draft report. Finally, in Phase 3 the draft country report was developed, reviewed, revised and finalised.

2.3.2 Data collection and analysis methods

Table 2.3 gives more detail on the data collection methods used in the study and how the information derived from these methods was used in this study.

The study combined use of qualitative and quantitative methods of evaluation. Qualitative approaches were largely used in assessing the factors facilitating and constraining the reforms of focus, and qualitative and quantitative methods were combined in analysing the actual and potential impact of these reforms.

Table 2.3: Details of data collection methods

Data source	Details	Use
1. Researcher knowledge	2 of the research team were interviewed and made notes on their experiences within aspects of the policy processes of focus	<ul style="list-style-type: none"> • general, subject to validation through other data collected
2. Document review	<p>Documents used included:</p> <ul style="list-style-type: none"> • contributions to, and reports of, policy debates pre-1994; • academic analyses of reforms pre- and post-1994; • official post-1994 policy documents and policy input papers; • consultancy and evaluation reports on the reforms of focus <p>(see reference list and additional bibliography)</p>	<ul style="list-style-type: none"> • understanding the context of reform • development of timelines for reforms of focus • identification of design details of reforms of focus • some use in policy characteristics and stakeholder analyses
3. In-depth interviews	<p>28 in-depth interviews, of which:</p> <ul style="list-style-type: none"> 2 with ANC politicians; 6 with national government officials (health and non-health); 5 with provincial government health officials; 15 with policy analysts from sectors outside government. 	<ul style="list-style-type: none"> • understanding the context of reform • development of timelines for reforms of focus • identification of design details of reforms of focus • policy characteristics analysis, stakeholder analysis and other policy analysis techniques
4. Media analysis	<p>Review of health coverage in twelve South African newspapers, using material collected by two established clippings services (Stock Press and the Co-operative for Research and Education).</p> <p>The papers were: Business Report, The Business Day, The Cape Argus, The Cape Times, The Citizen, The Financial Mail, Financial Week, The Sunday Independent, The Sunday Times The Star, The Sowetan, The Weekly Mail and Guardian</p> <p>Also review of The South African Medical Journal.</p>	<ul style="list-style-type: none"> • understanding the context of reform • some use in policy characteristics and stakeholder analyses
5. Parliamentary data	<p>Review of official parliamentary debates on annual Minister of Health budget speeches;</p> <p>Review of national Portfolio Committee on Health reports</p>	<ul style="list-style-type: none"> • understanding the context of reform • some use in policy characteristics and stakeholder analyses
6. Published evaluations	See references.	<ul style="list-style-type: none"> • assessing impact of the two free care policies, and of resource re-allocation policies
7. Secondary data	Government budget and expenditure data	<ul style="list-style-type: none"> • for additional evaluation of the impact of resource re-allocation policies
8. Report review process	<p>Inputs received from:</p> <ul style="list-style-type: none"> 4 government officials/advisers (health) 4 analysts from sectors outside government 3 international specialists 	<ul style="list-style-type: none"> • input into all aspects of report

The first step in the study was to capture the important knowledge of the reforms and related processes held by two members of the research team. The aim was explicitly to identify these researchers' understandings and perspectives independently of other data collection efforts, allowing their views then to be tested and validated against other data, through specific analytical approaches.

A very full document review aimed to analyse as much relevant documentation as possible. Documents were selected on the basis of their importance across the reforms of focus, their ability to provide an historical perspective and their accessibility. A generic framework was used to guide the document reviews and ensure a common, but open, approach to analysis. Following review of a first set of documents an initial coding structure was derived from consideration both of the information collected and the study's conceptual framework. This structure was then applied to, and fine-tuned in, subsequent document reviews. It categorised the information collected through the document review in relation to issues of relevance to the study, allowing documentary data to be fed into subsequent analysis. These data were used initially by different members of the research team who developed, for each reform of focus:

- timelines identifying the key steps in each reform's development and implementation;
- an analysis of key, relevant factors of context, and key actors directly involved in the reform;
- analysis of the detailed design of each reform;
- an initial 'policy characteristics analysis' for each reform – this analysis considers the potential for the design of a reform to influence support or opposition for it, its ease of implementation and so, ultimately, shape its impact (Gustafson and Ingle 1992).

In-depth interviews formed the core of the data collection process in phase 2. Interviewees were selected purposively – ensuring that many of those directly involved in reform development and implementation were interviewed and that the perspectives of different groups were obtained (e.g. national and provincial government officials, government officials and analysts outside government). A snow ball process also allowed the first set of interviewees to identify important people who they suggested should be interviewed as part of a second group. The interviews were open-ended in nature, although a series of broad guiding questions was developed for use within them – and adapted appropriately to specific interviewees. Interviews were either taped and transcribed, or detailed notes made during the interview were typed up immediately following the interview by the interviewer. Each interview was then coded broadly using categories derived from consideration both of the information collected, the document review coding structure and the study's conceptual framework. Individual members of the research team then developed initial analyses of these data by reform of focus and by the four broad factors likely to influence their evolution (context, actors, processes, and design). Such analyses supplemented those undertaken through document reviews, adding more detail to understanding specific aspects of policy formulation and implementation, and the role of different actors. Stakeholder analyses, in particular, allowed assessment of the actors involved in, and missing from, reform processes, their interests and concerns and position on specific reforms (Crosby 1997).

Media analysis and review of parliamentary data supplemented both document review and interviews, generating additional information of relevance to the issues of focus. The media analysis was not, therefore, a full analysis of the influence of the media over policy debates.

Finally, data drawn from published evaluations and some limited, additional analysis of secondary data allowed the impact of reforms to be assessed (see also section 2.4). No primary data collection was undertaken for this study.

2.4 Assessing impact

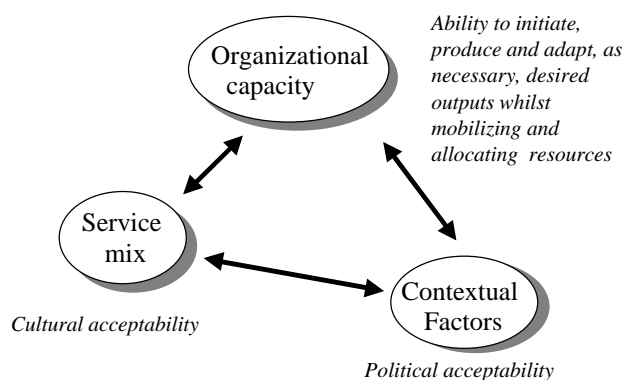
The study's assessment of the impact of the reforms of focus had four components. It sought to understand the impact of reforms on health equity and on health system sustainability. At the same time, it considered both the impact of the user fee and resource allocation reforms actually implemented in the period of focus (1994-99), as well as the potential impact of the social health insurance proposals developed but not implemented in this period.

The focus on equity is clearly of relevance in South Africa given the government's overall policy goal of redressing the social injustices of the past (see also **Chapter 3**). The specific objectives of the reforms of focus also illuminate the importance of equity as an objective by which to assess their impact (see Table 2.4). Whilst equity is a multi-faceted concept it is understood in this study as requiring consideration of the distribution both of the benefits and burdens of health care, and of the procedures by which those distributional decisions are made. The latter concern reflects a growing emphasis on procedural justice within an understanding of equity as, for example, applied to resource allocation debates (e.g. Gilson 1998a; Mooney 1996; Mooney 1998). It should be noted that although the Department of Finance's resource allocation formula is not a health sector policy it was considered within the study because of its influence on health resource allocation practices after 1996 (see **Chapter 4**).

Table 2.4: The stated objectives of the financing reforms of focus		
STATED OBJECTIVE	CLASSIFICATION ACCORDING TO IMPACT AREA	
	Health equity	Health system sustainability
<i>Free care for pregnant and nursing women, and children under six</i>		
to improve access to health services for pregnant and nursing women, and children under the age of six	✓	
to reduce maternal and infant mortality rates	✓	
to improve the health status of women	✓	
to promote family planning	✓	
<i>Free primary care for all South Africans</i>		
to improve access to basic health care for all South Africans	✓	
<i>The Department of Health's resource re-allocation formula</i>		
to distribute financial resources equitably between provinces	✓	
to shift resources away from higher towards lower level services	(✓)	(✓)
<i>The Department of Finance's resource re-allocation formula</i>		
to allocate public funds equitably and efficiently	✓	✓
to ensure the sustainability of public expenditure		✓
<i>Social health insurance proposals</i>		
to improve coverage and cross-subsidisation	✓	
to address the distortions of the private sector	✓	✓
to mobilise additional resources for the public health sector in a politically accepted way		✓
Note: bracketed ticks indicated an objective implicit in policy documents rather than one explicitly stated.		
Sources: African National Congress 1994a, 1994b; Department of Finance 1999; Department of Health 1994, 1996a, 1996b, 1997a; Health Care Finance Committee 1994; Ntsaluba and Pillay 1998; South Africa 1995; interview data.		

The Table also points to the relevance of sustainability as a policy objective against which to measure impact, even whilst suggesting it may be of less importance than equity in the South African context. This study, however, considered ‘sustainability’ as a critical aspect of the pursuit of social justice. Like equity, ‘sustainability’ has various aspects, and includes consideration of financial sustainability, combining the mobilisation of resources with improvements in allocative and technical efficiency, the political acceptability of reforms and the organisational capacity of the system to develop and implement reforms over time. Olsen (1998) has, for example, suggested that a health service is sustainable when operated by an organizational system with the long-term ability to mobilize and allocate sufficient and appropriate resources (manpower, technology, information and finance) for activities that meet individual or public health needs/demands. Figure 2.2 summarises the key aspects of health system sustainability considered in this study. Service mix can be understood as referring to the balance between levels of care in a health system. It influences health system ‘acceptability’ in relation to public demands, as well as public health needs.

Figure 2.2: Components of sustainability



In order to facilitate assessment against the two broad goals of equity and sustainability, several criteria were also identified for use in analysing the impact of reforms. Given data limitations, these criteria were used rather roughly. The equity criteria were:

(a) user fees:

- equal financial and geographical access/ utilisation for equal need;

(b) geographic resource allocation:

- equal expenditure per head of the ‘population’ between provinces, where the population used was only the uninsured population in line with the intention of the public health system to provide care to those who cannot afford private insurance. This criterion was recognised to fall short of measuring the different resource requirements of different populations. However, it was not possible to develop per capita estimates weighted for relative need - see also **Chapter 5**;

(c) social health insurance:

- extent of cross-subsidisation between insured and uninsured (and within insured population);
- equal access for equal need.

Across reforms the criteria broadly applied in assessing sustainability were:

- resource mobilisation levels/potential;
- the allocative efficiency of resource use;
- the acceptability of reforms to different stakeholders;
- the contribution of reforms to strengthening the health system's 'organisational capacity' (involving consideration of human resource availability, management systems, the networks of organisations involved in implementing a specific task and the broader institutional environment of these organisations: Hilderbrand and Grindle 1994).

For the reforms already implemented, analysis drew on relevant and available secondary data. However, as social health insurance had not been implemented by 1999, the analysis involved a critical appraisal of the design of key proposals in terms of their potential to promote equity and health system sustainability.

2.5 Ensuring rigour and validity in interpretative analysis

In analysis the research team was inevitably required to interpret the information it had collected in making a variety of judgements concerning both the actual and potential impact of the reforms of focus and the factors that have influenced their evolution and impact. Such interpretation cannot be avoided in a study of this kind and a variety of strategies were adopted to bring rigour and promote validity in the interpretative judgements that were made.

These strategies included:

- the involvement in the research team of both 'insiders' (researchers with detailed knowledge of the policy processes) and 'outsiders' (researchers with previously less involvement in the policy processes);
- developing and testing specific guidelines for review of all forms of documentation (including media analysis) and for in-depth interviews, based on the study's conceptual framework and their initial application;
- two steps of triangulation in data analysis – firstly, triangulation of information derived from a particular source of information (i.e. documents, interviews, media reports); and secondly, triangulation across these different sources of data;
- a careful and deliberate review process for the final draft report, allowing analyses to be tested against the judgments and views of South African key informants who have played a central role in relation to the reforms of focus and international reviewers with broader experience.

The process of data collection and analysis was, therefore, an iterative process, as summarised in Table 2.5. It required the research team to develop and refine interpretations and analyses, repeatedly testing individual researcher's judgements not only against those of other team members but also, more importantly, against those of the key informants involved in the final report review process.

Table 2.5: The iterative analytical process	
Activities of study	Steps in analysis and interpretation
<i>Team workshop 1 (October 1997):</i> Development of conceptual framework and overall research strategy >>	
>> Data collection phase 1 >>	Initial analyses: timelines, design details, contextual factors
<i>Team workshop 2 (March 1998):</i> Review of initial analyses >>	
>> Data collection phase 2 >>	Further analyses, including development of first input papers on each reform of focus
<i>Team workshop 3 (June 1998):</i> Review of first input papers >>	
>> Data collection phase 2 continuing >>	Further analyses, including development of input papers on factors of context, actors, processes and design across reforms of focus
<i>Team workshop 4 (Sept 1998):</i> Review of input papers >>	Preparation of draft one report chapters
<i>Team workshop 5 (January 1999):</i> Review of draft one chapters >>	Preparation of draft two report chapters
Review of draft two chapters by research team members and one international external reviewer >>	Preparation of draft three report chapters
Review of draft three chapters by South African and international reviewers >>	
<i>Team workshop 6 July 1999:</i> Discussion of reviewers' comments >>	Preparation of final report chapters

2.6 Use of data in the report

This report presents the final interpretation of health care financing reform experiences developed by the research team through the overall process of data collection, analysis and interpretation described above. It gives particular weight to the qualitative interview data that provide most insight on the central issues of the study – that is, the factors shaping the pattern and pace of reform, and their influence over impact. These interview data both underlie the interpretative analysis presented in the report - and are used directly (as specific quotations) to illustrate particular issues and perceptions. Documentary data were also used to supplement insights derived from the interview data, as referenced in the report. The specific quotes used in the report were deliberately selected either because they provide an example of a view commonly expressed, or because they reflect the view of a particular and important actor. In presenting these quotes, the anonymity of the respondents is preserved although, wherever possible, the respondent category (see Table 2.3) is identified.

Finally, the analysis of reform impact combines use of the research team's own analysis of available secondary data, published evaluation studies and their conclusions, as well as some interpretation of experience derived from interview data. The quotations used in this analysis were again selected, as described above.

2.7 Remaining methodological concerns

Despite the careful research process, four specific issues do influence the interpretative analysis presented in this report.

1. *The focus of the study:*

Through analysis of the information collected in this study it became clear that the focus on financing reforms gave the study a particular and, possibly, partial perspective on the overall process of health policy change in South Africa in the 1994-99 period. These particular reforms involved, for example, a different range of actors and groups than other health sector reforms. Whilst this study provides an insight into the broader process of health sector 'transformation' it does not, therefore, give a full view of that process. For example, it retains a clear focus on policy development at the national level because of the pattern of reform evolution in relation to both inter-provincial resource allocation and social health insurance. In addition, policies that are under development but are not yet widely known have not been fully reflected in this analysis.

2. *Researchers as past participants in policy processes:*

Recognising the role of some research team members in past policy processes, specific efforts were made to limit their potential influence over analysis and interpretation, as already discussed. This report, thus, presents the interpretation and judgements of the research team as a whole and not of specific members within it. However, there is some remaining potential for research team members' personal experiences to have coloured their judgements. Such experiences include not only direct involvement in past policy processes but also the continuing involvement of all team members in policy action, given the small and inter-linked government and non-government policy community. Clearly no analysis of this kind is entirely free of bias.

3. *Interviewee balance:*

Although efforts were made to ensure that those interviewed represented a balance of different perspectives, a higher proportion of analysts from outside government were interviewed than of government officials. This may have influenced the analysis presented here, although this pool of analysts itself includes a diverse range of people – working for academic, private, and non-governmental organisations. It also includes some people who were explicitly brought into policy processes under the new government, even if they were not directly employed by government.

4. *Interviewee access:*

The interviewee balance itself reflects some problems in accessing pre-identified government and political interviewees. Most importantly, it proved impossible to arrange interviews with either the Minister of Health of the period of focus, or her two Director Generals in the national Department of Health during this time. To offset this gap at least partially, efforts have been made to draw into the analysis publicly available interview data or materials produced by these individuals.

Annex 2.1: Analytical questions guiding data collection and analysis

1. What factors facilitate or constrain the likely effectiveness and impact of financing reforms?

Content:

- ⇒ what aspects of design for each reform of focus are most important to consider carefully because of their influence on the reforms' impact?
- ⇒ what linkages to other existing/planned reforms have been considered in developing the reforms of focus?
- ⇒ what are the respective benefits of introducing financing reforms singly or in a package?
- ⇒ if there is a clear difference between stated and underlying reform objectives, what significance does this have for the effectiveness of reforms and how effectiveness should be assessed?
- ⇒ what institutional changes are necessary to support the effective implementation of the reforms of focus? (who currently takes what decisions and how might this need to be adapted?)
- ⇒ what 'capacities' are necessary to allow effective decision-making in implementing the reforms of focus?

Actors:

- ⇒ which groups have supported and opposed the reforms and in what way, if any, has this support/opposition influenced the impact of the reforms?
- ⇒ how do the values of different groups influence their support or opposition for the reforms of focus?
- ⇒ which actors appear to have been most influential across reform or by reform? and why?
- ⇒ what incentives for behavioural change are introduced by the reforms of focus, and how do they influence effectiveness and impact?

Context:

- ⇒ in what way, if any, has the broad context of reform implementation influenced the design of reforms and their likely effectiveness?
- ⇒ what features of context appear to give which actors influence in the policy process?

Process:

- ⇒ is the impact of the reform influenced by the (non-)implementation the any parallel reforms?
- ⇒ what are the relative advantages and disadvantages of different implementation strategies, and how are these affected by the nature of the reform and the particular context of implementation?
- ⇒ what role can what types of information play in facilitating the process of reform?
- ⇒ what role can procedures for evaluating reforms play in furthering implementation?
- ⇒ what strategies have been used to generate support and counter opposition, and how successful have they been?
- ⇒ what steps can be taken to offset the possible negative impacts of reforms?
- ⇒ what are the most effective strategies for institutional reform and capacity development?

2. How can the impact of reforms be enhanced?

- ⇒ what conditions should be in place to achieve the achievement of objectives?
- ⇒ what adaptations of design and of implementation strategy are required?

The report concludes that improved delivery of services requires not just good policies or action to strengthen implementation capacity within the public service. Rather, developing the policy analysis skills necessary to manage the process of health system change is the critical foundation for improved service delivery. *'The gap between policy and implementation ... really lies with shortcomings in policy-making'*³.

A road map to this report

Chapters 1 and 2 outline the key questions asked, and methodologies used, in undertaking the evaluation of financing reforms in South Africa. The context for these reforms is explored in Chapter 3 in terms of historical events, societal pressures, capacity of government administration, the economy, and international pressures, and the range of other reforms that have complemented those in the health sector.

Chapter 4 discusses the roots and evolution of the financing reforms of focus. It maps out the key actors, debates and policy processes that developed and refined the reforms. The impact of the financing reforms implemented in South Africa between 1994 and 1999 is reviewed in Chapter 5, in relation to the key objectives of equity and sustainability. This chapter discusses the considerable achievements of these reforms, as well as their weaknesses. The remaining major challenges for financing reform are highlighted in Chapter 6, along with a discussion of the potential future contribution of a social health insurance system in addressing them.

Chapters 7-9 step back to weigh up the strengths and weaknesses of the process of policy development. Chapter 7 highlights the influence of contextual issues and key actors over policy initiation and design for all financing reforms. Drawing on this, Chapter 8 focuses down on the stalemate over SHI policy development, evaluating its causes. Chapter 9 then holds other issues of reform implementation up to the light of policy analysis. Chapter 10 starts by summarising the key findings of the report. Further, it provides recommendations about the development and design of future health financing reform in South Africa, while also unpacking the essential characteristics of a "good" policy process.

Those readers particularly interested in the processes of policy-making might look first at Chapters 3-4, and 7-9. Those particularly interested in the more technical, economic analysis of policy design and impacts might start with Chapters 4-7. Both groups of readers, however, should also read Chapters 1-2 and 10 to understand the roots and implications of the study.

What issues did the study look at and how did it examine them? (Chapters 2 and 3)

The study examined the three areas of financing policy change over the 1994-99 period:

- ◆ the removal of fees for both maternal and child care, and general primary care;
- ◆ the re-allocation of government budgets between provinces;
- ◆ the development of proposals for social health insurance (which also had links to proposals to strengthen the management of public hospitals as well as the introduction of new legislation to regulate the private insurance industry).

³ Friedman S. 1998. It's policy skills that are lacking, not capacity. *Synopsis* 2(3): 4-5.

Although a simplification of reality, the study's conceptual framework assumes a linear process of policy change, moving from agenda-setting around a reform of focus, to reform design, and then through implementation to the achievement of immediate and longer-term changes. The framework's primary focus, however, is on the detailed investigation of factors that influence the overall process of policy formulation and implementation, and so, ultimately, shape the nature and extent of change achieved by the reform. So, the 'design' of the policies that were introduced in each reform area was determined. Then the way in which these policies were developed and implemented, and the key people and steps of these processes, were investigated. Available evidence about the impact of fees and budget re-allocations on aspects of equity and health system sustainability were also assessed.

Information was drawn from reviews of policy-relevant documentation, broader literature concerning the reform areas and the context of South African policy development, newspaper analyses of health issues and relevant parliamentary speeches. Detailed interviews were conducted with key informants from both inside and outside government. Finally, data from existing evaluations as well as some additional budget and expenditure data were used in the assessment of impact.

The analysis of information from these different sources involved a process of interpretation – and this was undertaken with great care. A first step was to compare and contrast the information from different sources in order to seek confirmation of views and opinions as well as to identify different perspectives. In addition, a first draft report was sent out to review by a range of key informants, and their feed-back was considered when finalising it. A rigorous process is always important in analysing qualitative information. It was critical in this study because both the institutions involved in it have themselves been entangled, at some time or another, in the process of policy development reviewed in this report. Other factors that may have influenced the analysis include the difficulty of accessing some key actors, and that the focus on financing issues led to examination of particular sets of actors and processes, some of which were specific to the arena of health care financing reform.

What was the context and pattern of financing policy change? (Chapters 3 and 4)

The ability of the new government to deal with the legacy of the apartheid health care system was shaped by contextual factors. It is worth spelling these out to appreciate the extent of subsequent reform.

The reform of government required a complete reconceptualisation and re-organisation of the state and its relationship with society. In particular, the unification of previous administrations, and the restructuring of government into a quasi-federal arrangement, was an enormous and complex task. In parallel, the new government catapulted activists from the liberation movements into positions of power as politicians and civil servants. There they were confronted with an outmoded, inefficient and rule-bound bureaucracy subject to contradictory decentralising and centralising processes. At the same time, the emergence of new patterns of intergovernmental relations, and the special place afforded the private sector through the negotiation process, introduced a variety of new players into the process of policy formulation. The limited resource base compounded the problems produced by such structural changes. Previous patterns of

underdevelopment as well as new economic policies had the effect of limiting government taxation and spending. This constraint on budgetary resources was accompanied by strictures on human resource redeployment, as well as upward pressure on salaries through central bargaining arrangements.

Nevertheless, the new government made strong moves towards re-orienting service provision towards the needs of the population and away from those of historically powerful interest groups, such as the urban wealthy. In the health sector, two free care policies were implemented in the new government's first term of office. The first extended free health care to pregnant women and children under six, and the second, free primary care to everyone. Further, budgetary resources were re-allocated between geographic areas. This process also underwent two phases. In the first phase a needs-based formula developed by the Department of Health was used to determine provincial health department allocations. This approach was, however, overtaken by the second phase. Since 1996 the Department of Finance has determined the total block grant allocated to each province, and provincial administrations then allocate resources to each sector, including health.

In contrast, only slow progress had been made in strengthening public hospital funding and management by 1999. In addition, social health insurance (SHI) had not been implemented despite repeated and intense debate. It remains unclear whether the most recent SHI policy proposals, published in 1997, have sufficient backing from key actors to be implemented effectively. The development of SHI proposals also became divorced at this time from the development of private insurance regulation proposals although these were initially seen as part of the same policy package. While the broader SHI proposals became bogged down in debate, new legislation introduced in 1998 has moved to re-regulate the private insurance industry.

All these health care financing reforms had their roots in health policy debates amongst the 'progressive health movement' in the late 1980s. The debates then fed forward into the ANC Health Plan, published in 1994, which included proposals on all of the financing reforms examined in this study. However, the experience of taking forward these reforms after 1994 differed in three important ways:

- ◆ the speedy 'policy actions' of creating a health sector resource re-allocation formula and the removal of some public care fees was in direct contrast to the slow progress on public hospital fees and to the uneven process of 'agenda-setting' for social health insurance;
- ◆ although initial policy action on both fees and resource re-allocation occurred speedily, the nature of the processes through which these actions were implemented differed – fee removal involved two special 'one-off' policy actions, but health resource allocation policy evolved in response to changes in the broader governance pattern and structure of the country;
- ◆ while changes in resource allocation practice were almost immediately implemented through the routine budgetary process, the slow development of SHI policy through various special bodies led to policy proposals but no policy change.

What was the impact of reforms and what are the remaining challenges? (Chapters 5 and 6)

The financing policy changes introduced between 1994 and 1999 had clear potential to tackle some of the equity and sustainability problems within the health system. The two free care policies improved financial access to public care for specific vulnerable groups, and the use of the health sector resource allocation formula supported geographic re-allocations of public sector health budgets in favour of the formerly under-resourced provinces. The passing of the 1998 Medical Schemes Act, moreover, has the potential to tackle critical problems within the private insurance industry, such as cost inflation and risk selection, and so to have positive equity and sustainability impacts.

However, these successful policy actions also had drawbacks. Although the available data are limited, the two free care policies and the parallel budgetary re-allocations seem to have had a negative impact on the stability of the health system. Uncertainty in planning, poor morale of providers, declining quality of care and public disaffection with the public health system, are all by-products of reform which create a climate within which it becomes difficult to sustain system improvements. Favourable early trends in health budget re-allocations are, in addition, being jeopardised by the current process of allocating unconditional block grants to provinces given limited measures to encourage further health resource re-allocation. It is particularly important to establish and use 'norms and standards' for health care provision to influence future resource allocation patterns. Further action is also required to address the continuing inequities in health resource allocations within provinces.

And, finally, social health insurance, a reform ten years in the making, was not implemented. The failure to implement such a complex reform in only five years was, perhaps, inevitable, but the limited progress achieved in simply finalising a proposal that had adequate support to move towards implementation was disappointing. This represents a failure to find, within the context of constrained government expenditure, both an extra-budgetary source of funds and a mechanism to achieve greater cross-subsidisation between the private and the public health sectors. Such action remains essential in promoting equity and sustainability throughout the entire South African health system. At the same time, the inadequate action to date in tackling the weaknesses of public hospital funding and management has important implications not only for sustainability within the public health sector but also for the feasibility of introducing SHI.

Perhaps the most important design factor that limited the positive impacts of the different financing reforms was the weak linkage between financing policy change and other changes in the health system. Removing fees, for example, does not itself ensure that the services available are either geographically accessible or seen to be of sufficiently high quality to attract people to use them. Although important efforts were made to build new clinics in previously under-served areas, the impact of the speedy removal of fees on staff workloads had knock-on consequences for drug availability and staff morale that, at least in the short-term, appeared to jeopardise patient perceptions of the quality of care. Similarly, speedy and substantial budget re-allocations between provinces were not turned into the same level of real resource re-allocations because the existing civil service regulations restricted provincial Departments of Health from moving personnel between areas and facilities. This also constrained re-allocation between levels of care.

In general, financing policy appears to have taken second place over the 1994-99 period to specific interventions such as drugs policy or abortion. Yet a combined package of institutional and financing reforms is necessary to enable health system change to achieve its intended objectives. Health care financing policy change was, for example, undermined by the absence of linkages between personnel policy (including labour agreements) and the budgeting process, between hospital revenue generation and PHC development, and between hospital fee reform and social health insurance.

What explains the mixed picture of health care financing change? (Chapters 7 – 9)

The Department of Health has been held up as a department that delivered change – and the removal of fees has sometimes been given as a specific example of its commitment to addressing the legacy of the past. This policy action and the initial establishment of a sectoral resource re-allocation formula both generated political capital and provided some equity and sustainability gains. But the picture of financing policy change over the 1994-99 period is flawed both by weaknesses in the design of these policies and by the lack of action on some other critically financing important issues. As a result, the pattern of change may have provided the basis for longer-term equity and sustainability losses.

A central conclusion from the study is that the weaknesses in the overall pattern of policy action and inaction on health care financing issues since 1994 reflects problems with the underlying policy-making processes. Although policy design influences impacts, the roots of implementation failure – both the manner in which some actions have been implemented and the failure to implement others – lie in these problems.

The rapid, top-down implementation of the fee removal policies and the health resource allocation formula, for example, captured a window of political opportunity, but prevented the policies from being implemented carefully in consultation with those implementing them and in ways that would promote sustainability. Indeed, the reactions to these policies only heightened the low morale of health providers. The strong political leadership shown in initiating policy change represented, at the same time, poor leadership for implementation.

Speedy fee removal then shaped the nature of subsequent SHI proposals by limiting the SHI benefit package to hospital care. Such a package not only has technical weaknesses but also does not address the concerns of some key actors. The trade unions, for example, appear to have sought private primary care access for their members. SHI policy development was anyway a site of recurring disagreement between the technicians, who even before 1994 had begun to develop their ideas on possible design options, and the new policy-makers, who had little grounding in the earlier debates. By allowing differential care between the insured and the uninsured, even if only in hotel-like amenities, and by incorporating a role for the private sector in provision, several of the sets of SHI proposals sowed the seeds of opposition to them. The new policy-makers and their allies, the trade unions, simply did not accept that a system based on these lines was appropriate, whatever the technical arguments in its favour. As the new policy-makers sought 'equal access for all', in reaction to the discrimination of the apartheid era, the proposals simply made no sense to them. At the same time, the proposals never persuaded the newly empowered Department of Finance to set aside its

opposition to any form of earmarked tax. Yet the technicians repeatedly developed policy designs that had limited support, largely only from the private insurance industry. The new policy makers, on the other hand, repeatedly brought the technicians into policy development through special committees without clearly engaging with their arguments. The process of policy formulation remained a largely technical affair that allowed broader debate neither of policy goals and relevant strategies, nor of the concerns of different interested, or potentially interested, actors. The end result was a stalemate in policy development.

Finally, the initial health sector resource allocation approach was overtaken by the introduction of new budgetary processes in line with the creation of a semi-federal governance system. Under the new system provincial Treasuries have final responsibility for allocating resources to the health sector. But the highly political nature of this process has generated severe concerns for health budgets in some provinces and has required a new approach to resource allocation policy development. Provincial Departments of Health, in collaboration with the national department, sought to adopt a collective planning approach in thinking through the budgetary needs of the health sector, and had some success in developing conditional grants to protect aspects of provincial health budgets. However, although they initially sought to protect primary care, they had to accept the Department of Finance's preference to protect high-level hospital care through these grants. They were also unable, by 1999, to implement the 'norms and standards' that can influence budget decisions within provinces. Interestingly, although the technical complexity of this area of policy development mirrors that of SHI policy development, little economic expertise was drawn on to support health policy-makers in this task.

Across these three areas of health care financing reform, the most critical problems of policy-making were:

- limited public debate about the appropriate and feasible goals for the health system in the post apartheid era, particularly in relation to equity, and strategies for achieving them;
- little recognition of the importance of health financing matters in shaping the nature of health care provision and its impact on equity and sustainability;
- a combination of strong political leadership with weak structures and processes for providing technical advice on complex issues;
- limited availability of relevant technical expertise within the country, and weaknesses in the ways in which those with expertise were used in policy development;
- failure of reformers to engage a broad range of actors in discussion on some of the most fundamental issues of financing policy development, including the link between policy design and actor support or opposition for policy change;
- inappropriate patterns of engagement and consultation with different actors within specific policy processes;
- inadequate consideration of implementation needs and strategies within both policy design and the process of policy formulation;
- lack of preparation for policy implementation, such as limited action taken to develop the skills and systems required to allow effective implementation of financing – or other – policy;

- poor leadership of implementation, including a failure to set clear priorities for policy development, to build support before implementation, and to establish mechanisms for learning through experience.

Financing reforms are, of course, always highly contested and so difficult to implement. In addition, the radical transformation of the government and political bureaucracy since 1994 constrained all policy action. Nonetheless, actors shaped the processes and the policies that evolved from them. Their experience of managing policy change in a changing policy environment offers lessons for 'how to do things differently' in the future.

What lessons for the future can be drawn out of the past experience? (Chapter 10)

1. Strengthening Policy Formulation as a Foundation for Implementation

(a) Supporting Leadership by Providing Technical Analysis

Senior health policy-makers exercised considerable personal influence over decision making in South Africa between 1994 and 1999, in part because it was a time of rapid transformation within the health and governance systems. At the same time, the structures for channelling information and advice to these policy makers on health economics issues were quite weak. Perhaps as a result, health care financing policy appeared to receive less attention than other aspects of health policy development despite its importance to health system change. Aspects of priority setting and design development for health care financing were also weak. To strengthen future decision-making it may be important to review the existing mechanisms of providing technical support to health policy-makers and to establish procedures that enable regular contact with technical advisers. Opening up some policy issues, including overall health system and particular policy goals for broader debate, might also allow a timely flow of relevant information to decision-makers.

It is particularly important to strengthen the Directorate of Health Financing and Economics by improving its access to the highest level of government and promoting systematic dialogue between it and key reform managers and policy makers at both national and provincial levels. To make best use of the small, available pool of health economists it would be useful to clarify research needs as well as the objectives and nature of external analysts' involvement on any issue. Capacity short-falls in the area of health economics can also be addressed through long-term partnerships between government and key training institutions. However, the independence of non-government groups is an important characteristic of their particular contribution to policy debates.

Example: Policy-makers require good technical support in relation to the establishment and use of norms and standards to influence provincial health resource allocations. These norms must be compatible with national affordability criteria, so that provincial Treasuries can realistically be expected to fund the services from their unconditional block grants. Consideration must also be given to the services to be covered by the norms. Specific attention needs to be given to maintaining the secondary referral services that are critical in the effective provision of primary care, but that may be overlooked in policy development.

Technical analysis is also important in tackling intra-provincial health budget inequities.

(b) Strengthening the Strategic Skills and Awareness of Technicians

It is vital for government technicians, as well as non-government policy analysts, to recognise the importance of strategy as a complement to technical analysis. The 1994-99 experience shows, for example, that where the technical design of a financing policy matched the values of policy elites, and the broader political goals with which they were associated, there were fewer barriers to implementation. Political buy-in was a necessary pre-condition for further policy development. Understanding the power, value bases and concerns of major actors in the health sector is a first step in managing the process of policy change. It provides the basis for developing strategies that create alliances in support of reforms and offset opposition. It also allows reforms to be designed in recognition of actors' interests. In addition, as inappropriate presentation of technical inputs can impede reform, consideration of the dominant values of key political actors will help analysts appropriately frame their policy inputs. Complex reforms anyway need to be communicated clearly and simply both to policy makers and the broader public. This need not sacrifice technical detail.

Knowledge of relevant analytical techniques as well as possible strategies of action are important in addressing these issues. The particular role of special committees, for example, needs to be thought through carefully. They can help strengthen policy formulation, for example, by protecting the task from the administrative burden of government, supplementing government's skill base, or allowing broader representation of key actors. However, if planned poorly, they may also frustrate policy development. Technicians may choose to collaborate with others who have relevant skills in developing their strategies.

Example: Technical and political analyses must be combined in clarifying the possible alternatives for a future social health insurance system. Five key steps that will provide a foundation for further SHI policy development are:

1. undertaking a comprehensive analysis of the extent of cross-subsidisation within existing health care spending patterns;
2. reconsidering the motivations and objectives of cross-subsidisation in health care spending within the context of South Africa's social objectives, in part through dialogue with key actors;
3. analysing the extent to which alternative SHI proposals achieve the desirable level of cross-subsidisation;
4. considering the acceptability of new proposals (and other options) to key actors, and the risks associated with implementing the reform as presently configured;
5. reviewing considering the separation of SHI from the conventional medical schemes environment and the nature of the benefits to be covered through SHI (in part to ensure that they offer members advantages over current services).

(c) Building Implementation Concerns into Design Development

As in many countries, the development and design of policies did not involve those tasked with their implementation. The consequences included poor implementation practices and negative impacts, as noted in relation to the free care policies. Involving representatives of mid-level managers and providers as advisers in policy formulation may be important in strengthening the eventual implementation of reforms. In addition, 'policy champions' should be identified to enable the work of special policy processes to be fed forward into implementation.

2. Strengthening Implementation Processes

(a) Working Within a Changing Policy Environment

The structural change and institutional flux during the government's first term of office undermined the capacity both for policy development and for policy implementation, weakening the impact of the reforms. In a changing structural environment it is important to recognise the costs of 'trying to do too much too quickly', even whilst accepting that problems demand urgent action. When institutions are being reformed and new lines of management and roles and responsibilities are being developed, the priorities for policy action need to respond to concrete and identifiable problems as well as building political support for a broader reform agenda. In addition, these priorities must be rooted in clear analysis and understanding of key health problems, how reforms might address these problems and the sequencing of policy actions required to support the implementation of complex reform. Enhancing the capacity for future policy development and implementation is also likely to be an important building block for continuing reform.

(b) Enabling Implementation through Leadership

It is critical to improve central co-ordination and facilitation of implementation. Particularly important is greater dialogue and consultation with those who implement policy. This will require a clear specification of roles and responsibilities between the tiers of government, and structures for co-ordinating action between managers at these levels. Strengthening skills and systems for implementation is also important – and more gradual implementation processes can enable such capacity development.

Example: Although some technical analysis is needed in conceptualising norms and standards, their effective implementation will require a well-managed process. It will be particularly important to build support with provincial Treasuries, as well as with mid-level and facility managers.

(c) Planning for Implementation

Although it may be important to take advantage of 'windows of opportunity' to introduce policy change, rapid change at such times may generate problems for further reform. Important steps in planning for implementation always include identifying the potential obstacles to change, preparing guidelines to support change, and identifying the capacity needs to implement change. The gradual implementation of reforms can also allow some details of policy design to be determined through experience. Complex reforms may anyway need to be broken down into phases or stages to enable their implementation, particularly where they involve establishing new institutions. Such stages also need to be planned in advance, as the policy environment may change and leave the complex reform only partly implemented. Reformers must ask whether the individual steps toward the

reform meet objectives in themselves. If not, then the cost or risk of failing to implement all the steps must be considered beforehand.

Example: The implementation of SHI must be preceded by improved hospital billing and fee systems, revenue retention as part of enhanced decentralised hospital management, and a mechanism for ensuring the equitable distribution of all resources available to public sector services. Similarly, the effective implementation of any mechanisms for influencing resource distribution between and within provinces requires that budgetary changes are accompanied by new approaches to personnel decision-making, and that capital and recurrent budgeting is more closely linked.

(d) Securing Better Policies through Monitoring and Evaluation

Monitoring and evaluation systems are vital in allowing the effective evolution of reforms to meet key objectives. They should allow assessment both of what progress towards objectives is achieved by any policy change and of the factors influencing the degree of progress. A central aspect of reform evaluation should be to gain a better understanding of the broader public's view of reforms. Existing information systems may need to be strengthened to include regular data on key indicators for reform. Non-government analysts can play a role in designing effective evaluation systems, given critical national resource constraints, and in implementing some evaluation activities.

Examples: There is an opportunity to prepare for the evaluation of the 1998 Medical Schemes Act in advance of its implementation, and to keep a watching eye over its equity and sustainability impacts. It is always important to monitor the impact on geographic equity and level-of-care spending patterns of resource allocation policies. Such assessment of the existing conditional grants, as well as any new policies developed in the future, will be critical in informing further policy development. Equity could also be introduced as a key element of monitoring the implementation of the government's medium-term expenditure framework.

3. Towards Delivery: Strengthening the Policy Process

Finally, the study highlighted six key principles to guide the development of a policy process that will lead from policy change to change in delivery practices. They are:

1. Financing reform should pay attention to the 'art' of politics rather than just the 'science' of technical analysis
 - both to enable change and to ensure that it does not become the preserve of the few with the relevant knowledge;
2. Financing reform should be placed at the heart of health system development
 - both because it has a wide-ranging influence over the patterns of health care provision and use, and because it must be supported by parallel institutional changes;

3. Financing policy should be developed through a relatively open and transparent process
 - to allow broader, public debate about the goals and strategies of policy; but 'closed' decision-making may be useful in identifying policy options on the basis of publicly debated goals or in developing detailed design proposals in relation to specified options;
4. Information is a critical element in financing policy development
 - both formal data and, despite their informality, the views and opinions of the public and key actors;
5. The roles of different groups of technicians and analysts in financing policy development must be clear
 - to enable best use of the limited, available health economics' resources;
6. Implementation should be an integral element of financing policy development
 - rather than being seen as an activity that somehow automatically follows policy development and that does not require policy management skills.

Overall, the study emphasises that, in implementation as in policy formulation,

"policy analysts cannot continue to ignore the how of policy reform"⁴.

⁴ Walt G and Gilson L. 1994. Reforming the health sector in developing countries: the central role of policy analysis. *Health Policy and Planning* 9(4): 353-370.

ACKNOWLEDGEMENTS

We are sincerely grateful to the many people who have given us their time during the course of the South African country study of this project, agreed to be interviewed, lent us documentation and provided us with detailed feed-back on our analyses.

We would particularly like to thank the following reviewers of the draft country report:

South Africa

Dr Jonathan Broomberg
Dr Jud Cornell
Dr Nicholas Crisp
Dr Steven Friedman
Mr T. Patrick Masobe
Prof. William Pick
Dr Yogan Pillay
Dr Malcolm Segall

International

Dr Sara Bennett
Dr Charlotte Leighton
Dr Gill Walt

Finally, we thank our colleagues from the University of Zambia, the Swedish Institute for Health Economics, and the London School of Hygiene and Tropical Medicine for their collaboration in undertaking this two-country study.

We, nonetheless, of course take full responsibility for the report and our final conclusions.

Funding for the overall project was provided by:

- ***USAID's Partnerships for Health Reform*** project, through its Major Applied Research grants programme;
- ***The European Union*** (through INCO-DEV research funding, contract number ERBIC18-CT97-0218);
- ***The South African Medical Research Council***, through the Centre for Health Policy's MRC Research Group on Health Policy.

Lucy Gilson is a part-time member of the Health Economics and Financing Programme of the London School of Hygiene and Tropical Medicine, UK, which receives funding from the UK's Department for International Development.

TABLE OF CONTENTS

EXECUTIVE SUMMARY	I
CHAPTER ONE STUDY BACKGROUND	1
1.1 Justification	1
1.2 Purpose, aims and objectives	1
1.3 Areas of focus	2
1.4 Relevance of study to South Africa	4
CHAPTER TWO STUDY FOCUS AND APPROACH	5
2.1 Period and reforms of focus	5
2.2 Conceptual framework and research questions	5
2.3 Overview of research strategy and methods	8
2.4 Assessing impact	11
2.5 Ensuring rigour and validity in interpretative analysis	13
2.6 Use of data in the report	14
2.7 Remaining methodological concerns	15
Annex 2.1: Analytical questions guiding data collection and analysis	16
CHAPTER THREE THE CONTEXT OF HEALTH FINANCING REFORM	17
3.1 The historical context	17
3.2 Political change	22
3.3 Administrative restructuring	26
3.4 The new economic policy	31
3.5 New health structures and policies	35
3.5 Conclusion	38
CHAPTER FOUR THE ROOTS AND EVOLUTION OF HEALTH CARE FINANCING REFORMS BETWEEN 1994 AND 1999	39
4.1 Evolution within the health care financing policy community before and after 1994	39
4.2 Health care financing debates 1980s-1994	42
4.3 Structures for health care financing policy development 1994-99	45
4.4 Resource allocation and budgeting reforms 1994-99	48
4.5 Taking action on public health care fees after 1994	53
4.6 Working towards a policy agenda on N/SHI 1994-99	54
4.7 Summary: health care financing reforms 1994-99	58
Annex 4.1: Details of resource allocation formulae, South Africa 1994-99	62
CHAPTER FIVE UNDERSTANDING THE IMPACT OF FINANCING POLICY CHANGES	65
5.1 Assessing impact	65
5.2 Assessment of resource allocation policies	66
5.3 Assessment of free care policies	77
5.4 Summary and conclusions	80
CHAPTER SIX ADDRESSING CRITICAL HEALTH CARE FINANCING REFORM CHALLENGES: DOES SHI HAVE A ROLE?	83
6.1 Key continuing equity and sustainability challenges	83
6.2 The potential role of social health insurance in addressing these challenges	87
6.3 Issues to be resolved if SHI is to be taken forward	93
6.4 Summary and Conclusions	97
	99

CHAPTER SEVEN INITIATING POLICY CHANGE: COMMON EXPERIENCES	
7.1 Developing policy during a time of radical change	99
7.2 The central role of actors in policy development	103
7.3 The sources of actors' influence	109
7.5 Limited health economics capacity and understanding in the DOH	115
7.6 Lack of clarity in the equity goal of health policy	117
 CHAPTER EIGHT THE STALEMATE IN SHI POLICY DEVELOPMENT	 119
8.1 Complexity of SHI policy design and poor clarity of policy objectives	119
8.2 The interaction between actors and policy design	120
8.3 Weaknesses in the strategies applied within SHI policy development	127
8.4 Failing to engage in public debate	136
Annex 8.1: Data sources for analysis of actor positions on N/SHI options	137
 CHAPTER NINE DELIVERING POLICY CHANGE: COMMON EXPERIENCES	 139
9.1 Links between policy development and implementation processes	139
9.2 The pitfalls of a speedy, 'top-down' approach to implementation	140
9.3 Weak leadership for implementation	143
9.4 Weaknesses in provincial implementation capacity	146
 CHAPTER TEN RECOGNISING THE DYNAMICS OF POLICY CHANGE	 151
10.1 Overview of experience: health care financing policy change in South Africa, 1994-99	151
10.2 Strengthening policy formulation as a foundation for implementation	153
10.3 Strengthening implementation directly	161
10.4 Strengthening policy design	164
10.5 Towards 'delivery': strengthening the policy process	174
Annex 10.1: Overview of the pattern of health financing policy achievements, and explanatory factors, 1994-1999	182
Annex 10.2: Strengthening the processes of health care financing development and implementation in South Africa (with specific reference to SHI and Norms and Standards)	184
Annex 10.3: Summary of international experience concerning the ways in which SHI may have positive and negative impacts on equity, efficiency and sustainability	188
Annex 10.4: Designing mechanisms for improved cross-subsidisation from private to public sectors in South Africa	190
 REFERENCES	 193
 ADDITIONAL BIBLIOGRAPHY	 206

TABLES, FIGURES AND BOXES

	Page
<hr/>	
Tables	
Table 2.1: Reforms of focus in South Africa	5
Table 2.2: Summary of research strategy	8
Table 2.3: Details of data collection methods	9
Table 2.4: The stated objectives of the financing reforms of focus	11
Table 2.5: The iterative analytical process	14
Table 3.1: Infant mortality rates by population group	18
Table 3.2: Sources of finance for the health sector (1992/93)	19
Table 3.3: Indicators of the availability of public sector health care resources between magisterial districts (1992/93)	20
Table 3.4: Provincial distribution of public sector health care resources across the population excluding medical scheme beneficiaries (1992/93)	21
Table 3.5: Data on health care expenditure and health status in South Africa pre-1994 and countries that have comprehensive health expenditure data	21
Table 3.6: What does the RDP 'mean'?	32
Table 3.7: Key elements of the new government's main health policy statement	36
Table 3.8: Health policy reforms 1994-99	37
Table 4.1: Details of health care financing special committees 1994-99	47
Table 4.2: Key changes in resource allocation practice 1994-99	50
Table 4.3: The evolution of health financing reform	61
Table 5.1: Comparison of different population data sets	75
Table 5.2: The main achievements and limitations of financing reforms	81
Table 5.3: Overview of key design issues and effect on impact	82
Table 7.1: Summary of key actors and their roles in relation to the reforms of focus 1994-99	105
Table 7.2: The sources of actors' influence over health care financing policy development	113
Table 8.1: The objectives of S/NHI proposals	120
Table 8.2: Actor positions in relation to different N/SHI design options	121
Table 8.3: Factors shaping the special committees' design and functioning	131
Table 8.4: Engaging key actors in formal policy structures	133
Table 9.1: Key implementation features of selected health reforms	140
<hr/>	
Figures	
Figure 2.1: The SAZA study's conceptual framework	6
Figure 2.2: Components of sustainability	12
Figure 3.1: Infant mortality rate gradients across income quintiles for the African and Coloured population groups	18
Figure 3.2: The mechanisms through which GEAR intends to achieve its objectives	34

	Page
Figure 4.1:	Key stages of NHS/NHI proposals, pre-election 44
Figure 4.2:	Annual budget cycle, post-1996 50
Figure 4.3:	Key stages of NHI/SHI proposals, post-election 56
Figure 4.4:	The chronology of health financing policy development in South Africa, 1994-99 60
Figure 5.1:	The routes through which the health care financing reforms of focus had the potential to tackle inherited problems, and be supported in this by other policies 66
Figure 5.2:	Percentage difference between total real per capita provincial health expenditure (1995/96 & 1996/97) and budgets (1997/98-2000/01) and the national average 68
Figure 5.3:	Percentage difference between real per capita provincial health expenditure (1995/96 and 1996/97) and budgets (1997/98 - 2000/01) (excluding academic hospitals) and the national average 68
Figure 5.4:	Percentage difference between per capita provincial health expenditure (and provincial free health care budgets) and the national average 70
Figure 5.5:	Comparison of estimated 1994/95 provincial expenditure with target allocations based on the Function Committee and Doherty and van den Heever (1997) resource allocation formulae (% share of total provincial health care expenditure/budget) 72
Figure 6.1:	The routes through which the poorest of the poor may still be excluded from benefits (1999) 84
Figure 6.2:	Cross subsidy implications of the Committee of Inquiry and Department of Health's 1997 SHI recommendations 92
Figure 7.1:	Forcefield Analysis, Conditional Grant 2 104
Figure 8.1:	Forcefield Analysis, 1995 SHI proposals (COI) 128
Figure 8.2:	Forcefield Analysis, 1997 SHI proposals 128
Figure 10.1:	Sources of information for governmental decision-making 178

Boxes

Box 3.1:	The main apartheid policies that protected white privilege 17
Box 3.2:	The White Paper's contextualisation of health policy within the ideology of the RDP 26
Box 3.3:	Some problems that plagued intergovernmental relations, 1994-1999 27
Box 3.4:	The characteristics of the bureaucracy inherited from the apartheid state 29
Box 3.5:	Reasons for slow delivery by the RDP of its development-oriented projects 31
Box 4.1:	Health conditional grants introduced since 1997/98 51
Box 4.2:	Key actors in the budget process since 1996 52
Box 4.3:	Media reporting around the 'Deeble option' 57
Box 5.1:	The main policies supporting re-prioritisation of spending on lower level services 69
Box 5.2:	Example of media headlines on public hospitals 73
Box 5.3:	A comparison of policy statements on user fees by the ANC Health Plan and RDP 79
Box 6.1:	Promoting the sustainability of public hospitals through an enhanced public-private interface 86
Box 6.2:	Estimated fee revenue under a SHI 88

	Page
Box 7.1	Statements on health in relation to broader socio-economic development
Box 7.2	Media reporting on health policy conflicts
Box 7.3	Views of Minister Zuma
Box 7.4:	Views on health policy issues from the DOF
Box 7.5	Equity goals established in the 1997 White Paper for the Transformation of the Health System in South Africa (Republic of South Africa 1997)
Box 8.1:	Strategic consultation with the insurance industry in developing the 1998 Medical Schemes Act
Box 9.1:	Implementation of free PHC in the Free State province
Box 9.2:	Common criticisms of the DOH
Box 9.3:	GEAR and the 'unfunded mandates' of provinces
Box 9.4:	The continuing problems of hospital and district health management in South Africa
Box 9.5:	Hospital billing systems, a case study of poor administration systems
Box 10.1:	Nineteen strategies for working with actors
Box 10.2:	Lessons from the South African Health Function Committee formula that reflect and reinforce international experience
Box 10.3:	Norms and standards in the education sector
Box 10.4:	Lessons from the South African experience of developing SHI proposals that reflect and reinforce international experience
Box 10.5:	International experience concerning the financing and other reforms required for effective implementation of SHI policy

ABBREVIATIONS

ANC	African National Congress
CHP	Centre for Health Policy
COI	Committee of Inquiry
COMS	Concerned Medical Schemes
COSATU	Congress of South African Trade Unions
DDG	Deputy Director General
DHFE	Directorate of Health Financing and Economics
DHS	District Health System
DIB	Demographic Information Bureau
DOF	Department of Finance
EDL	Essential Drugs List
FFC	Financial and Fiscal Commission
GDP	Gross Domestic Product
GEAR	Growth, Employment and Redistribution Strategy
GNU	Government of National Unity
GP	General Practitioner
HCFC	Health Care Finance Committee
HEU	Health Economics Unit
HSP	Hospital Strategy Project
IDASA	Institute for Democracy in South Africa
IFP	Inkhata Freedom Party
M&E	Monitoring and Evaluation
MCH	Maternal and Child Health
MDM	Mass Democratic Movement
MECs	Member of the Executive Council
MINMECs	Minister and Members of the Executive Council meeting
MTEF	Medium Term Expenditure Framework
NDOH	National Department of Health
NGO	Non-government Organisation
NHI	National Health Insurance
NHS	National Health System
NP	National Party
PHC	Primary Health Care
PHRC	Provincial Health Restructuring Committee
PDOH	Provincial Department of Health
RAWP	Resource Allocation Working Party
RDP	Reconstruction and Development Programme
SACP	South African Communist Party
SAHRA	South African Health Resource Allocation formula
SMT	Strategic Management Team
TOR	Terms of Reference
UNICEF	United Nations Children Fund
VAT	Value Added Tax
VSP	Voluntary Severance Package
WHO	World Health Organisation

CHAPTER FOUR THE ROOTS AND EVOLUTION OF HEALTH CARE FINANCING REFORMS BETWEEN 1994 AND 1999	39
4.1 Evolution within the health care financing policy community before and after 1994	39
4.2 Health care financing debates 1980s-1994	42
4.3 Structures for health care financing policy development 1994-99	45
4.4 Resource allocation and budgeting reforms 1994-99	48
4.5 Taking action on public health care fees after 1994	53
4.6 Working towards a policy agenda on N/SHI 1994-99	54
4.7 Summary: health care financing reforms 1994-99	58
Annex 4.1: Details of resource allocation formulae, South Africa 1994-99	62

CHAPTER FOUR

THE ROOTS AND EVOLUTION OF HEALTH CARE FINANCING REFORMS BETWEEN 1994 AND 1999

This chapter describes four sets of issues that shaped the experience of health financing reform between 1994 and 1999: the health care financing policy community; the roots of the post- 1994 reforms; design details of each reform of focus; the mechanisms and processes used in Chapters 5-9.

4.1 Evolution within the health care financing policy community before and after 1994

The health care financing reforms debated and implemented in the 1994-99 period have their roots in the broader policy discussions of the late 1980s. The ‘mass democratic movement’ (MDM), which fought against the apartheid regime from inside the country, drew a vibrant and active range of political and community activists, labour groups, youth and women’s groups and professional organisations into political struggle focused around issues to do with basic political, economic and human rights. The ‘progressive health movement’ of this time also brought together exiled and internal members of the various liberation movements (most notably the ANC), progressive health worker organisations and networks, and academics. Initially these health activists were more concerned with using the various health professional fora as places of opposition to the apartheid government, or providing health care for detainees, than in debating future health policy options. Yet in the early 1990s, after the unbanning of the ANC and as the likelihood of real political change drew closer, those concerned for the future ‘post-apartheid South Africa’ became increasingly engaged in policy debate. Recognising the need to shift some of the focus of health activities from “*defiance to reconstruction and development*” (South African Health Workers’ Congress President, quoted in Centre for the Study of Health Policy 1990: 1), a range of research and analysis was undertaken to identify policy options for the post apartheid South Africa. This fed into a variety of briefing papers, conferences, meetings and discussions. Of particular importance was the 1990 Maputo Conference, where the issues of focus included mechanisms for funding health care and the role of the private sector in the future health system. These discussions then fed forward into the development of the ANC National Health Plan which itself stimulated further policy debate.

The development of this Plan involved an iterative process of proposal development, debate, further development, further debate and so on. A range of issue-specific ‘commissions’, composed of analysts in the relevant field as well as more general activists, initially drafted policy proposals in their areas of focus (interview data). These proposals were then debated within ANC structures and fine-tuned, before being released in draft form for wider public review and comment (African National Congress 1993). There was a huge response to the proposals from individuals, community organisations, representative associations of private providers and the private insurance industry, with thirty-three formal submissions from institutions alone (African National Congress 1994a). Every effort was made to build consensus across these diverse groups:

“once we got the second draft, we then sat down with almost every organisation that gave an input and took them through the process of saying this is what you said, this is what we’ve incorporated for these reasons, so we went through a whole process of debating with them until we won them over. And they really appreciated this. To them they weren’t so much

concerned about what was coming out of the document but that the ANC was seen to be taking them seriously." (ANC health department official, interview data).

Through the development of the Health Plan even potentially antagonistic stakeholders were engaged in health policy debates, in line with the broader negotiation process that preceded the 1994 elections. *"We always spoke about how that period from 1990 to 1994 was a window of opportunity, where in a way both State structures and the private sector were going to be made more amenable to ideas about change than before or after that period"* (health activist, interview data).

At the end of the consultation process a small editorial team comprising members of the ANC's Health Department and external technicians from WHO and UNICEF spent two intense weeks combining all the different inputs into a coherent final document. As a member of the final drafting team noted, *"I have this picture of [team member] wielding this enormous pair of scissors, cutting and pasting"* (interview data). The Plan was then published just before the 1994 elections.

Working under these immense pressures of time and diverse political demands, there was, however, little opportunity for careful, detailed policy work. Health financing proposal development was, therefore, described by one participant as *"not a very profound process"* whilst the initial proposals were *"internally contradictory"* (interview data). Some also suggested that, despite the open and wide-ranging policy debates within the progressive health movement, the more technical financing issues were largely the product of a few thinkers. *"I think the economics of it was seen as something fairly technical and that people who were au fait with those areas and had a particular interest in bridging public health and economics were in a sense the key people who developed ideas around that"* (interview data). Not surprisingly some of the others involved in the policy debates on these issues suggested that they were almost as much educative as substantive (interview data). Overall, however, the final version of the Health Plan was well received by health activists and given high public profile by the ANC.

The first democratic elections of 1994 were obviously a watershed for the country as a whole. In the health sector, a new Minister, Dr Nkosazana Zuma, was appointed. A leading member of the ANC in exile, Dr Zuma is a medical doctor with experience of working in the rural areas of South Africa. Although involved in aspects of the ANC Health Plan's evolution, she had not been directly involved in health care financing discussions and had played little role in the finalisation of the Plan. One of her first actions was to appoint two special advisers drawn from outside the existing civil servant pool to assist with the initial steps in health sector transformation. Together they then moved to re-configure the national Department of Health's (DOH) organisational structure to better serve the needs of the new era. For example, a Directorate of Health Financing and Economics was created to co-ordinate and drive health financing policy development. New personnel were recruited into this unit as part of the general move towards transforming the civil service from apartheid bureaucrats to a wider mix of political appointees, health activists as well as career civil servants.

Another early action of the new national Minister of Health was to appoint a series of 'ministerial commissions', including the Health Care Finance Committee, to *"inform policy and planning approaches within the Ministry"* (Tollman and Rispel 1995: 78). Each committee was composed drew on both new government personnel and analysts from outside government – such as selected members of the private health services, professional associations, non-governmental organisations (NGOs) and academics.

Personnel changes at national level were paralleled at provincial level, first, by the appointment of provincial Ministers of Health (known as MECs, members of the executive committee of the provincial premier). Second, Strategic Management Teams composed of

existing health civil servants as well as health activists from outside government were appointed to initiate the process of provincial transformation in the health sector. The job of these teams was “*to re-design the health services, determine priorities for provinces and prepare for implementation*” (former Strategic Management Team member, interview data: see also Gilson *et al.* 1996; Tollman and Rispel 1995). Many of those working within SMTs were subsequently appointed permanently to provincial Departments of Health.

Out of these structural and personnel changes it soon became clear that Dr Zuma would become the leading figure in health policy development in the new government’s initial term of office. She played a critical role across almost all aspects of health policy development and her name became almost synonymous with health reform in South Africa at this time. Her admirers suggest that she almost single-handedly sought to redress some of the most iniquitous legacies of the past, pursuing a policy path she believed was in the best interests of the country. The electronic Mail and Guardian commented in 1997, for example, that “*Dr Nkosazana Zuma’s Health Department is systematically revolutionising South Africa’s health-care system*” (May 26th 1997) – and this is supported by a former ANC official, who said “*I think that health is one of the Ministries that has come out best in terms of biting the bullet on some very untenable things*” (interview data). At the same time, her actions were strongly criticised by her political opponents, who appeared to hold her personally responsible for pursuing what they perceived to be ideologically bound policies. For example, in 1996 the Democratic Party spokesman on health said that Dr Zuma sought “*a complete socialisation of our health care services*” (Republic of South Africa 1996: 2224), and then again in 1998 a Member of Parliament from the Inkhata Freedom Party suggested that she was implementing “*failed Marxist health policy*” (The Star, March 23rd 1998). The former Minister was also dogged by a series of apparent mistakes and problems during her term of office. The 1995 ‘Sarafina II’ controversy, in which funding from the European Union was incorrectly used to support the development of an AIDS’ awareness play, was a continuous source of media and political criticism of both the Minister and her Department until 1999. However, much of the personal criticism from Dr Zuma’s political opponents seems likely to reflect the fact that during her term of office, she and her Ministry took on several important “*vested interests and admirably fouled up their featherbed*” (Weekly Mail and Guardian, November 13th 1998).

Dr Zuma’s strong role in health policy debates in the 1994-99 period was, however, also a consequence of the importance of the new government across all national policy communities and debates. Therefore, from 1994 the role of analysts from outside government changed from developing and driving processes, to supporting the new government’s personnel within its own-initiated processes. In part this change clearly reflected the legitimate role of the first democratically elected government of the country, but also, over the 1994-99 period, the new civil servants’ growing skills and experience.

The increasing dominance of government also accompanied, and may have been the cause of, some reduction in the size and vigour of wider policy communities, including the health policy community. Many of those who had been part of the broad anti-apartheid movement before 1994 moved into government at either national or provincial levels after the elections. In their new jobs they had to cope with new systems, procedures and immense pressure ‘to deliver’, leaving little time to engage in policy debate (interview data). Their being in government may in itself have dampened policy debate to the extent that those remaining in civil society organisations fell into the trap of thinking, “*People in government are our comrades in the liberation movement. How can I stand up ... and criticise these people? I’d rather take them aside and whisper something in their ear*” (policy analyst, interview data). The ‘loss’ of their personnel to government positions anyway constrained the functioning of some of these organisations, many of which also faced financial problems as the external donor funding they had previously received came to be channeled instead through government. These specific constraints in turn both reflected and were exacerbated by a

broader issue. Despite having worked together within the anti-apartheid opposition movement before 1994, tensions occurred between the ANC and civil society after the election around the nature of the latter's participation in government decision-making (Friedman and Reitzes 1996). Whilst some in the new government thought that the diversity and independence of civil society organisations was important in contributing to debate and critiquing government actions, others appeared to think that they should simply implement government policy (interview data).

Another aspect of change experienced within the health policy community after 1994 was a move towards sub-communities focussing on specific policy areas, each with their own 'flavour'. The AIDS policy community, for example, drew together a broad range of organisations, including research groups, human rights groups, the gay movement, and NGOs serving those with HIV and AIDS. It was very vocal in its public criticism of government policy actions and in its lobbying activities (Schneider 1998). In contrast, financing issues seemed to become ever more seen as primarily the preserve of economists, with policy debates often taking place behind closed doors and focussing on technical issues. The core group of the health financing policy community in the 1994-99 period was, therefore, very small, composed largely of new government health officials and analysts based in either academic research or consultancy groups. There were close links between these groups, not least because some of the government officials were recruited from the non-government groups. Other actors who played active roles within the health financing policy community on this period included government officials from the national Department of Finance and from some provincial Departments of Health. Representatives of the private insurance industry also continued their active engagement in the debates following their inputs into the ANC Health Plan. Finally, international health economists had an influence – through their direct participation in some of the formal policy processes, their personal ties to specific members of the community or their broad support of some of the specific positions presented in policy debates. Although small, the health financing policy community was not homogeneous in its views but because it was small, individuals inevitably played important roles in relevant policy debates.

4.2 Health care financing debates 1980s-1994

A central element of health care financing debates in the late 1980s was consideration of the relative merits of moving towards a tax-funded national health system (NHS) in the UK mould, versus a national health insurance system (NHI). Proposals for an NHS had circulated in activist circles since the mid-1980s (de Beer *et al.* 1988; Owen 1988) and were influenced both the never-implemented recommendations of the South African Gluckman Commission of 1944 and by the World Health Organisation's 1978 Alma Ata declaration on Primary Health Care (de Beer 1988; de Beer *et al.* 1988; Marks 1988). However, as Figure 4.1 illustrates, from the 1980s a series of NHI proposals were developed and NHI ultimately came to be accepted by many, but not all, as the policy of preference.

One of the main points of contention in the discussions underlying the evolution of policy concerned the role of the private sector. Where the NHS model envisaged almost no role for it, the NHI proposals all accepted that it would continue to exist and even allowed for it to take on additional roles as contracted primary care providers or, perhaps, administrators of the insurance funds (de Beer and Broomberg 1990a,b; Picard 1992). Some of those who favoured the NHS option argued that an approach that drew the private sector into health system development in any way would undermine the public system. Instead, the private sector should be left to self-destruct through its cost-inflationary practices and every effort should be made to develop a financing plan to strengthen the public sector in isolation from it (Zwarenstein 1990). In addition, although the NHS proposals aimed for a unified and centrally planned health system, by 1992 the NHI proposals had come to acknowledge that

there would probably be some limited ‘tiering’ within the system. Better ‘hotel’ care (amenity services) would be offered within public facilities to those whose care would be financed through the NHI scheme (Picard 1992).

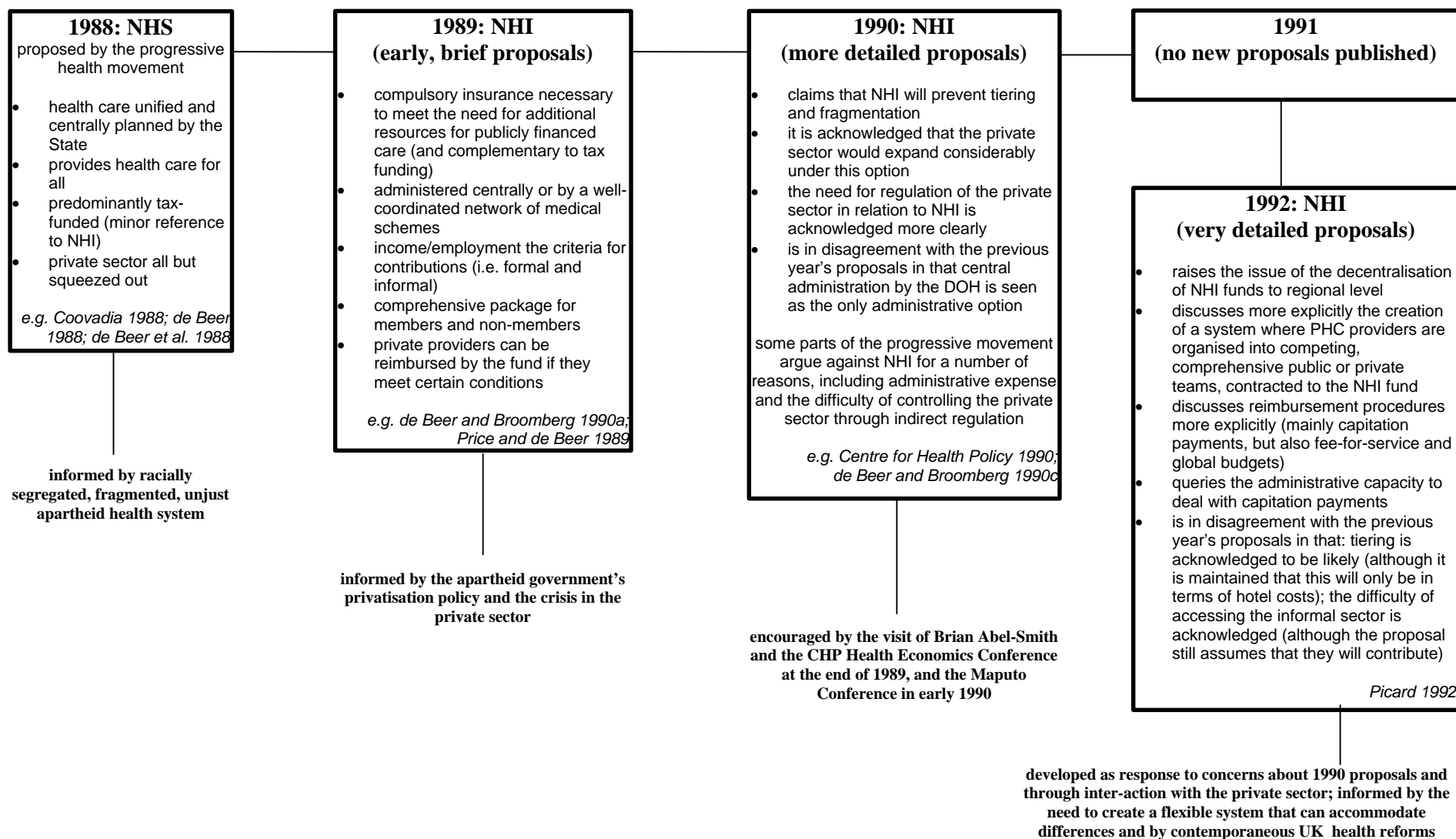
The primary proponents of NHI at this time were analysts working within the Centre for the Study of Health Policy (CHP), a research unit attached to the University of Witwatersrand. CHP’s thinking was partly influenced by non-South African analysts working in the field, such as Professor Brian Abel-Smith of the London School of Economics and Political Science, who encouraged their move towards a NHI approach. At the same time, the CHP analysts drew three important conclusions from available analyses of the South African health system that then went on to influence post-1994 policy development:

- that a tax-funded NHS would be neither politically nor financially feasible given that health care already absorbed a relatively high proportion of GDP (de Beer and Broomberg 1990a,b), estimated as nearly 6% at that time (McIntyre and Dorrington 1990);
- that the private sector was simply too extensive to disappear and so the only politically feasible approach was to work with it (Centre for Health Policy 1990; de Beer and Broomberg 1990a,c);
- that, given the enormous disparity in funding of the two sectors, the central requirement of future financing policy would be to bridge the resource gap between the public and private sectors (Centre for the Study of Health Policy 1989; de Beer and Broomberg 1990c).

“Our feeling was that a UK NHS model would not work. It didn’t bridge the fundamental resource mal-distribution” and this was “the fundamental argument ... The only way to bridge this resource gap is to use public funds to contract private providers” through a NHI system (CHP analysts, interview data). In addition the CHP analysts argued that an NHI system would ensure central co-ordination and could facilitate the implementation of mechanisms to regulate the private sector, such as provider payment mechanisms that would support cost containment (de Beer and Broomberg 1990a,b). In any case, they suggested that NHI was an important first step on the road to a future NHS-type system: “all tax-based systems have evolved out of health insurance schemes. Therefore, health insurance becomes a necessary stage in the transition from privately funded to tax funded health systems” (de Beer and Broomberg 1990b: 28).

Two other strands of health care financing analysis undertaken at this time by economists working in or with the Health Economics Unit at the University of Cape Town, focused on public sector resource allocations and user fees. Piecing together the huge disparities in allocations between geographical areas of the country they, first, developed proposals around a needs-based re-allocation formula. Named SAHRA (South African Health Resource Allocation), the proposed formula was rooted in the English Resource Allocation Party (RAWP) formula and so was based on differential population size, weighted for demographic composition and mortality, as well as including a ‘Service Increment for Teaching’ component. The application of the SAHRA formula to 1989/90 budget data created an awareness that significant resource re-allocation from the former provinces to the former homeland areas was urgently required (Bourne *et al.* 1990; McIntyre *et al.* 1991). The second analysis, of international and South African experience with user fees, emphasised both that fees are often a regressive financing mechanism, particularly deterring utilisation by the poorest, and that revenue levels are undermined by the administrative costs associated with their implementation (McIntyre 1994a).

Figure 4.1: Key stages of NHS/NHI proposals, pre-election



All three above areas of analysis had a clear influence over the development of the ANC Health Plan (interview data). Thus, the financing policy agenda (African National Congress 1994a) for the new government called for:

- free health care for pregnant women, nursing mothers and children under six, and for other ‘vulnerable groups’ (such as the elderly, disabled and some chronic patients);
- full cost charges for those with medical insurance treated in public hospitals, and partial retention of fee revenue at hospital level;
- a process, driven by the national DOH, for reallocating health sector resources taking account of relative need, local revenue generating potential and plans and budgets developed at lower levels;
- some system of national or social health insurance (SHI), with the specific recommendation that a commission be established to investigate the appropriateness and economic feasibility of an NHI system through consultation with all interested parties, and to undertake detailed planning for this option if it should have sufficient consensus.

Interestingly, while the main financing sections of the Plan were drawn primarily from the ANC’s Health Care Financing Policy Commission, the proposal to remove fees for pregnant women and children under six came from the Maternal, Women and Child Health Commission. It was rooted in moral and clinical arguments: *“We just felt that at the first point of contact in the formal health care system children should be treated free as they are the most vulnerable group in society”* (Commission member, interview data). This particular proposal was then picked up in the ANC’s Reconstruction and Development (RDP) Programme. As the ANC’s election platform, the RDP laid out the vision of the post-apartheid society that the ANC wished to create, and the economic and social policy actions it had prioritised in pursuit of this vision (see **Chapter 3**).

4.3 Structures for health care financing policy development 1994-99

The elections of 1994 not only led to the appointment of a new national Minister of Health but also to the development of new structures that then took forward health care financing policy development. This section provides some basic information on the key health policy structures of the 1994-99 period, before describing the pattern of policy development in each of the three reform areas of focus. The relevant structures included not only formal bodies within government but also a series of special structures.

4.3.1 Key health policy structures within government

As already noted, one of the first actions of the new Minister of Health was a review and overhaul of the existing organisational structure of the national DOH, resulting in the creation of a Directorate of Health Financing and Economics to lead policy development in this field. Equally importantly, however, given the post-1994 quasi-federal governance structure within the country (see **Chapter 3**), was the creation of two bodies to ensure co-ordination in policy-making across provinces and between the national level and provinces. The health ‘MINMEC’, like its counterparts in other sectors, brings together all nine provincial MECs for health and is chaired by the national Minister of Health. Its counterpart is the Provincial Health Restructuring Committee (PHRC) which brings together the heads of the provincial departments of health, and is chaired by the national Director General (equivalent to a permanent or principal secretary). Both bodies meet regularly but whereas senior civil servants often accompany MECs to the MINMEC politicians never attend the PHRC. The PHRC has on occasion established smaller working groups to address specific issues and is itself supported by other inter-provincial committees which co-ordinate action in particular policy areas (see section 4.4.2). Such committees report to the PHRC and MINMEC from time to time, and identify policy issues for discussion and action at these higher levels.

4.3.2 Special structures for health care financing policy development

Outside the routine structures of government, five special structures were established over the 1994-99 period to address aspects of health care financing policy development. Four of these were committees and, as Table 4.1 makes clear, there were considerable differences in their terms of reference, membership, size and operation. The first two were large, formal committees, established by the DOH with wide-ranging terms of reference, particularly the Health Care Finance Committee, and a short time span. In contrast, the latter two were much smaller in size, focused on specific aspects of the N/SHI agenda, and more 'internal' to the DOH.

There was considerable dis-continuity in membership across the committees. Although the first head of the DOH's Directorate of Health Financing and Economics was involved in all four committees, the non-government health policy analysts involved in the latter two committees were different from those involved in the first two. Whilst an official of the Representative Association of Medical Schemes (the main private insurers' body of the time) participated in both the Health Care Finance Committee and the Committee of Inquiry into a national health insurance system, only the Committee of Inquiry had representation from the Department of Finance. A final influential figure across committees was an Australian economist, Dr John Deeble. Initially invited to participate simply as one of the international advisers to the Health Care Finance Committee, he quickly gained the ear of the Minister and became the only international health economist to be involved over a longer period of time. He participated directly in the first two committees and then, although not a member of the SHI Working Group, continued to offer advice to the Minister in 1997 (interview data).

Special pieces of analysis were undertaken for all committees, either by individuals on the committee or, in the case of the Committee of Inquiry, commissioned from outside analysts (interview data). There were varying degrees of consultation across the committees – from none in the case of the Health Care Finance Committee, to wide-ranging consultation in the Committee of Inquiry – the only body that called openly for submissions on its terms of reference or that conducted public hearings across the provinces. The Medical Schemes Working Group, in contrast, conducted an intensive consultation process with different stakeholders, within a deliberate strategy. Although SHI was not an element of its terms of reference, this also provided a vehicle for some consultation around the SHI Working Group's proposals.

Although the Health Care Finance Committee report was not initially made public, aspects of it were leaked to the press and so became publicly debated. In contrast, the draft Committee of Inquiry report was made publicly available for comment before it was finalised. A briefer document was also prepared and submitted to the health MINMEC and then Cabinet (interview data). The reports of both the SHI and Medical Schemes Working Groups were both discussed within formal structures, such as the MINMEC and disseminated through consultation with selected stakeholders, but were not distributed for public debate. Across all committees, only the Medical Schemes Working Group resulted in actual policy and legislative change – in the form of the Medical Schemes Act of 1998.

Table 4.1: Details of health care financing special committees 1994-99				
	1994 Health Care Finance Committee (HCFC)	1995 Committee of Inquiry into a national health insurance system (COI)	1997 Social Health Insurance Working Group	1997 Medical Schemes Working Group
Roots	<ul style="list-style-type: none"> ANC Health Plan recommendation; One of several committees established by DOH to advise it in 1994 	<ul style="list-style-type: none"> HCFC call for further technical analysis, political decision & broad consultation on NHI; HCFC debates 	COI call for appointment of technical committee to take forward SHI/regulation proposals (& subsequent lack of action)	
Terms of Reference (TOR)	<ul style="list-style-type: none"> Cost free MCH care & extension of free primary care to all uninsured Make recommendations on fees for all levels of health system Make recommendations on fee levels for insured and revenue retention rates Examine appropriateness and feasibility of establishing an NHI system, or for other models to enable all South Africans to have access to comprehensive health services at an affordable cost Explore compulsory service for medical graduates Provide recommendations on a needs-based resource allocation process for allocating budgets to provinces 	<p>Initially intended to prepare a detailed, phased and costed plan for the introduction of a national health insurance system, or a publicly supported alternative, with the aim of ensuring access to PHC services for all South Africans;</p> <p>BUT later revised to allow broader investigation of NHI options; Committee also investigated regulation of medical schemes although not part of TOR</p>	To develop detailed proposals for a SHI scheme supporting public hospital use	To prepare new legislation on medical schemes regulation
Duration	June-November 1994; five meetings	Jan-April 1995	Jan – May 1997 (but subsequent ad hoc meetings)	late 1996 – late 1997
Chair	Two chairs, a health policy analyst (3 meetings) and a health service manager (2 meetings)	Co-chairs: Special adviser to Minister of Health and health policy analyst	Financing Adviser to DOH (funded by European Union)	Member, DOH Directorate of Health Financing and Economics
Membership	17 members: <ul style="list-style-type: none"> 7 South African analysts; 6 national/provincial government health officials; 1 private sector analyst; 3 international analysts 	13 in total: <ul style="list-style-type: none"> 3 South African analysts; 3 national/ provincial government health officials; 2 national finance department officials; 2 private sector analysts 3 international analysts 	6 in total: <ul style="list-style-type: none"> 3 South African analysts; 3 national health officials 	6 in total: <ul style="list-style-type: none"> 2 South African analysts; 4 national health officials
Reporting point	Special Adviser to Minister of Health	Director General, DOH	Deputy Director General, DOH	Deputy Director General, DOH
Activities	Technical analysis & debate within committee only	<ul style="list-style-type: none"> call for submissions technical analysis & debate within committee; commissioned research; consultation with stakeholders 	<ul style="list-style-type: none"> technical analysis 	<ul style="list-style-type: none"> technical analysis; consultation with stakeholders
Products	Report to Minister, December 1994 (aspects leaked to press)	<ul style="list-style-type: none"> initial report to MINMEC & Cabinet; draft report published for comment mid 1995, finalised 1996 	report to MINMEC, released as DOH policy document September 1997	Medical Schemes Regulation Act 1998
Sources: Department of Health 1997a, 1997b; Health Care Finance Committee 1994; South Africa 1995; Interview data				

The fifth and final special structure engaged in developing health care financing policy proposals in the 1994-99 period was the 'Hospital Strategy Project', paid for through European Union funding to the national DOH. A consortium of four consultant and academic groups implemented this technical assistance project: Monitor Company, Health Partners International, the Centre for Health Policy and the National Labour and Economic Development Institute. Working within a defined set of parameters, the Project undertook a broad review of management and resourcing in the public hospital sector, including specific assessment of the public hospital fee structure (Monitor Company *et al.* 1996). Its work was mostly conducted over a one year period from August 1995, and involved an intensive process of technical analysis as well as consultation with national and provincial health officials (interview data). Between February and June 1996, for example, four drafts of proposals for a national fee schedule were circulated for comment to national and provincial officials, and three presentations were made to PHRC meetings. The bulk of the proposal was, finally, approved at a MINMEC meeting in March 1996 - although some specific modifications were requested for re-submission to the July 1996 meeting.

4.4 Resource allocation and budgeting reforms 1994-99

The development and implementation of resource allocation reforms occurred within and through the normal process of government budgeting and so had to adapt to the broader evolution of these budgeting processes. As a result, there were two very different phases of resource allocation policy within the 1994-99 period.

4.4.1 The design of resource allocation approaches

As Table 4.2 highlights, the first resource allocation phase was governed by a health sector formula that supported population/needs-based re-allocations of budgets between provinces. However, the formula's application was overtaken by the second phase of resource allocation policy, the era of 'fiscal federalism'. Since the 1997/98 fiscal year the national Department of Finance (DOF) has allocated unconditional block grants to provinces on the basis of a formula intended to reflect differential levels of overall provincial 'need'. Provincial Treasuries then have responsibility for allocating these resources between sectors. In this new environment the national DOH cannot determine health resource allocations across provinces. The constitution does, however, allow national government to legislate minimum norms and standards to ensure "*uniformity across the nation*" (Act 108 of 1996; Section 146(2b)), while allowing provincial discretion about the exact mode of service delivery. The DOH can, therefore, develop specific health care 'norms and standards', that provide direction over patterns of service provision, as well as 'conditional grants', that ring-fence funding for specific purposes, to influence how resources are allocated and used across provinces. Whilst several health conditional grants had been introduced by 1999, there had been little progress in developing norms and standards.

The principle underlying the health sector formula used in the Function Committee era was that of 'financial equity', interpreted as a goal of achieving 'equal weighted health expenditure per head' across all provinces. This goal was to be achieved within a five year time period, and thirty percent of the required redistribution was planned for the first year of its application (Department of Health 1994; interview data). As the further details provided in Annex 4.1, Box A indicate, a crude weighting process took account of differences in socio-economic status between provincial populations (initially based on per capita income level and then medical scheme membership levels). These differences were assumed to reflect the differential health needs of provinces, on the grounds that population groups of different socio-economic status have different levels of health need. Allowing for socio-economic status in population estimates also reflected the principle that public sector services should

primarily serve the uninsured, lower income populations. At the same time, through the 'top slice', funding for specialised services and training at academic hospitals, seen as 'national functions', was protected.

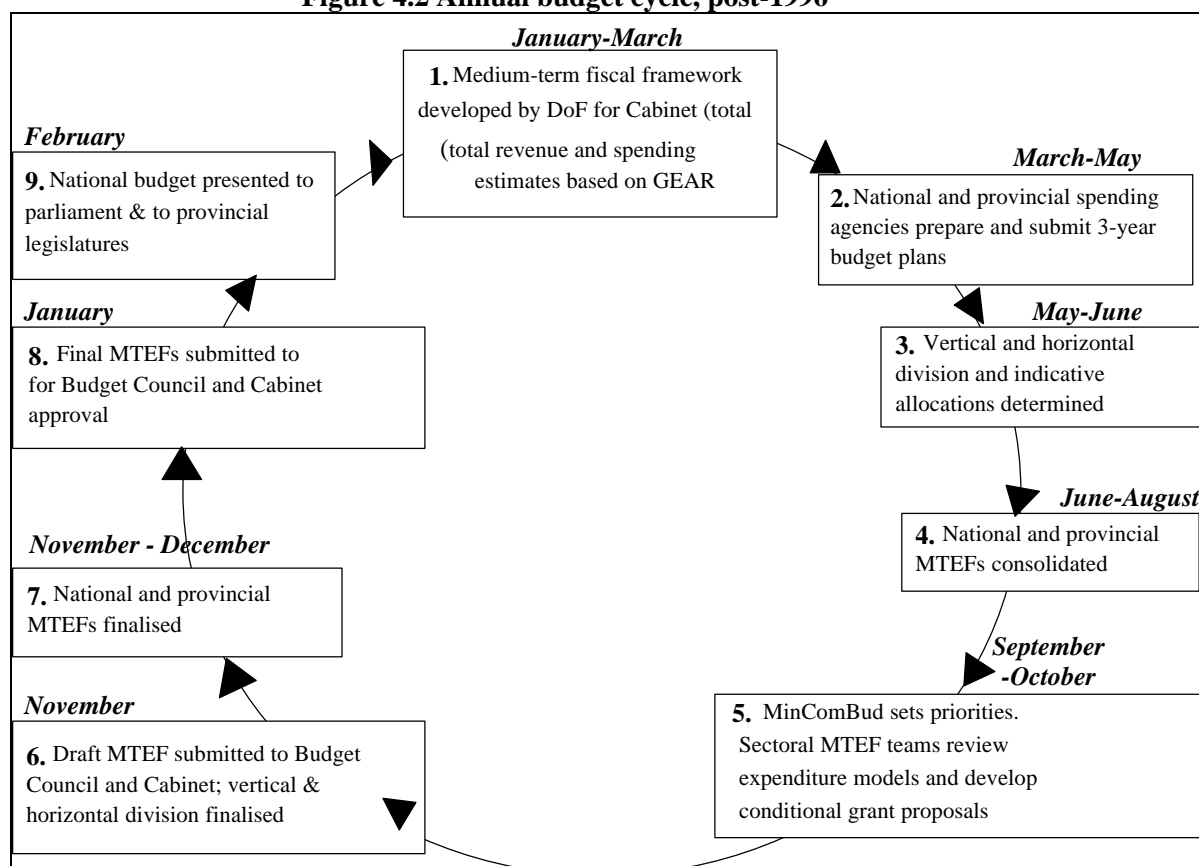
The move to fiscal federalism resulted from the introduction in 1996 of the new constitution, which finalised the post-1994 governance structure of the country. The change in resource allocation practice was accompanied by major changes in the budgeting process. Since the 1997/98 financial year the DOF has set the parameters for budgeting, in particular the upper limit on the total government budget, through its medium-term fiscal framework. This limit is, in turn, shaped by the deficit targets within the government's macro-economic policy, 'Growth, Employment and Redistribution' (GEAR). Once developed, the fiscal framework is submitted to Cabinet for approval and provides the basis for the rest of the budget process (see Figure 4.2).

As noted in Table 4.2, allocations between levels of government and between provinces are made through the 'vertical' and 'horizontal' divisions of the total government budget. The vertical division is intended to reflect the spending responsibilities of the three spheres of governance. In practice, the relative distribution of resources between national and provincial levels remained constant over time. In 1999, excluding debt service costs and money set aside in a contingency reserve, over 44% of government resources were allocated to the national sphere, about 54% to the provincial sphere (including conditional grants), and 1.3% to the local government sphere (Department of Finance 1998a). The formula underlying the horizontal division more closely reflects the earlier health sector formula as it includes population-based and other weighting factors that are intended to allow for differential needs between provinces (see Annex 4.1, Box B). It is inevitably, however, much wider in scope, allowing for differential need across social sectors and in relation to infrastructure, as well as for differential contributions to the national economy.

Within the overall budget cycle outlined in Figure 4.2, the vertical and horizontal divisions have finally to be reconciled with, and reflected in, provincial and sectoral budgets. This happens through the process of developing the provincial and sectoral Medium Term Expenditure Frameworks (MTEF), that is, three-year rolling budgets. First introduced in preparing the 1998/99 budget, the MTEF encourages departments to plan over a longer period and to link budgets and planned outputs. Initial budget estimates are developed by all spending agencies at provincial and national levels (Step 2, Figure 4.2). Provincial Treasuries later develop consolidated provincial budgets on the basis of these initial estimates (Step 7), whilst also ensuring that the final figures fall within the guideline allocations determined through the vertical and horizontal divisions (Steps 3 and 6). At this time they must also take into consideration a requirement introduced in 1998, that 85% of the total provincial budget should be allocated to social services. Subject to subsequent negotiations (Step 8), the estimates developed then go on to form part of the final national budget that is presented to parliament (Step 9).

Table 4.2: Key changes in resource allocation practice 1994-99		
Principles	Phase 1: Function Committee era (financial years 1995/96-1996/97)	Phase 2: Fiscal federal era (financial years from 1997/98)
Budget of focus, & main allocation steps	total national health sector budget, allocated between (a) government levels & (b) then between provinces	total government budget, allocated between (a) government levels, & then (b) by sector within provinces
Process of budget determination	annual process	medium term expenditure framework introduced in preparing budgets from 1998/99 financial year that requires three year rolling budgets
Allocation practice: Between government levels	'top slice' initially deducted from total health budget included the allocation for the national DOH	'vertical division' of budget determines allocation between three spheres of government, central, provincial and local (but only determined after 'top slice' take from budget to cover projected debt servicing costs, commitments to international bodies, & to create contingency reserve)
between provinces	budget remaining after 'top slice' allocated between provinces on basis of a population/needs based formula (calculated differently in 1995/96 and 1996/97)	'horizontal division' of provincial allocation between provinces based on population-based estimates of need, plus costs of maintaining existing provincial infrastructure
between sectors	not relevant	provincial treasuries allocate between sectors, within guideline introduced in 1998 that 85% of total budget should be allocated to health, education and welfare sectors
between levels of health care	initial 'top slice' included allocations for: training, research & specialised services by Academic Health Centres; nurse training; funding for recurrent cost of new primary care clinics being built with separate funding (latter only in 1995/96)	'conditional grants' since 1997/98 financial year have ring-fenced nationally determined levels of funding for certain services (see Box 4.1)

Figure 4.2 Annual budget cycle, post-1996



Notes: DOF = Department of Finance; MinComBud = Ministers Committee on the Budget; MTEF = Medium Term Expenditure Framework

Source: Presidential Review Commission 1998

A central issue for the health sector within the budget cycle of fiscal federalism has become how to protect, at least, health sector allocations in the competition between sectors that now occurs at provincial level. Whilst the 85% guideline is one measure to this end, a series of health 'conditional grants' were also agreed with the DOF and given to provinces from the 1997/98 financial year. Together these grants represented approximately half of all government conditional grants in 1999 (Department of Finance 1999). Although health officials initially expressed a clear preference for protecting primary over hospital care (interview data), the conditional grants finally agreed primarily focus on, and so protect the funding of, certain types of hospital services (Box 4.1). The level of funding protected varies by different amounts in each province depending on the province's existing facility profile. Grants 1 and 2 also reflect the understanding that academic hospitals are a national resource and so should be controlled at national rather than provincial level. They build on the Function Committee's inclusion of a national increment for teaching, education and research (NITER) in its formula. Grants 3 and 4 are intended to work hand in hand with the second grant in supporting the development of appropriate levels of tertiary care services in all provinces through a dual process of rehabilitation/construction and re-distribution of the recurrent funding for this function. A critical requirement for the effective implementation of these grants is, however, the determination and costing of national and tertiary functions. Given the difficulty of this task, it is not surprising that one provincial health official interviewed in 1998 commented that, "*they've been talking for 18 months now on what the conditions are and how it's going to work and they still don't seem to have finality on it*" (interview data).

Box 4.1: Health conditional grants introduced since 1997/98

The health sector conditional grants are for:

1. research and training of health professionals (all provinces);
2. central hospital specialist services situated in Gauteng, Western Cape, Free State and Kwa-Zulu Natal to cover the costs of the use of these services by residents of other provinces;
3. developing certain tertiary services in provinces currently not providing them (the 'redistributive' grant);
4. hospital rehabilitation and construction;
5. the primary school nutrition programme;
6. the construction of a new Durban academic hospital and upgrading of Umtata regional hospital.

The DOH's intention is to release these funds to provincial health department as and when they meet the conditions of each grant, that is, the submission of business plans detailing how the resources will be used. Provincial departments are, thus, accountable for the expenditure of the funds and the national department is responsible for monitoring compliance with the conditions of the grant (e.g. submission of an acceptable plan, and then adhering to it)

A final resource allocation concern identified in the 1994-99 period was the inequity of health resource allocations within provinces (Gilson *et al.* 1997; Makan *et al.* 1997). Yet, although some provincial Departments of Health had begun to consider the issue (Brijlal *et al.* 1997), only limited action had been taken to reverse these inequities by 1999.

4.4.2 The actors involved in resource allocation policy

The key decision-making group in the first period of resource allocation after 1994 was the inter-provincial health Function Committee, a structure inherited from the apartheid era. Bringing together both national and provincial health department representatives and other actors, this committee determined the formula that would guide health sector resource allocations in the first three financial years of the new government. A rushed process, the key meeting of the Function Committee was held in December 1994 when in the space of three days a formula that would achieve inter-provincial equity in five years was agreed. Those

involved commonly suggest that one of the new Special Advisers to the Minister was one of the most important actors and she “...*basically pushed that process very much in the way that it went*” (health policy analyst, interview data).

The era of fiscal federalism was accompanied by a substantial increase in the influence of the national Department of Finance in the budget and resource allocation process, given its central role in setting budget parameters (see Figure 4.2). Other national institutional actors that came to importance within budgeting in 1996 are summarised in Box 4.2.

Box 4.2: Key actors in the budget process since 1996

The Budget Council *i.e.* the Minister and deputy Minister of Finance, the nine MECs of Finance, the heads of the provincial treasuries and the Director Generals of the Departments of Finance and State Expenditure:

- makes recommendations on all key budgeting issues to Cabinet, and provides the link between the macro-economic framework and the expenditure agents within the public sector which have the mandate to deliver services (Financial and Fiscal Commission 1996);
- it is “*probably the most influential forum in the entire budget process*” (Presidential Review Commission 1998: 20).

The Ministers’ Committee on the Budget (MinComBud) *i.e.* the Minister and deputy Minister of Finance, and the Ministers of Trade and Industry, Arts and Culture, Science and Technology

- sets broad government priorities for approval by Cabinet

Parliamentary Portfolio Committees composed of members of parliament or members of provincial legislatures

- have “*oversight over the health department nationally and provincially ... [they are] the eyes and ears of the people*” (budget analyst, interview data).
-

Established as an independent agency outside the routine structures of government by the interim constitution in 1994, the Financial and Fiscal Commission (FFC) was also intended to play a leading role in the general maintenance of inter-governmental financial and fiscal relations (McIntyre *et al.* 1995). It was specifically tasked with making recommendations to the Budget Council on national priorities for the resource allocation process (Portfolio Committee on Health 1997), as well as advising national and provincial legislatures about the allocation of financial resources through a formula (Pintuwitz 1996). However, the influence of the FFC appeared to wane over time even as the DOF became more influential, and some of its recommendations on allocation practice were apparently ignored (McIntyre *et al.* 1999).

In the health sector, budget and resource allocation issues became a regular and central focus of debate within the PHRC and the health MINMEC. In addition, several other structural mechanisms evolved to allow more effective debate of the issues amongst the various participating bodies. The health sector MTEF task team, co-ordinated by the DOF, was established in 1997 as one of several sectoral task teams charged with developing expenditure models for their sector, considering policy choices, developing norms and standards and making recommendations on conditional grants. The health MTEF team initially focussed on reviewing health budgets from an efficiency perspective, assessing the allocation of resources between programmes within provinces as well as differences between provinces in unit costs (Department of Finance 1997; McIntyre *et al.* 1998). This task team was strengthened in 1998 and a new body created to support it, called the “four by four”. The “four by four” brings together one official each from the national departments of health and finance, as well as three provincial health and three provincial treasury officials. It seeks to improve co-ordination on budget issues particularly at provincial level. Joint finance and health MINMECs are also being held to improve co-ordination and communication (interview data).

Despite the influence of analytical work before 1994 on the development of a health sector resource allocation formula (i.e. the SAHRA work), little subsequent analysis undertaken outside the DOH appeared strongly to influence this aspect of health policy. Even the deliberations on resource allocation of the Health Care Finance Committee had no influence over the Function Committee's parallel process of policy development (interview data). Analysts working outside government, nonetheless, continued to address resource allocation issues through self-initiated analysis, commissioned analysis and consultancy support to official bodies. This body of work included evaluation of the approaches adopted, alternative proposals and assessment of impact in terms of re-allocation (see **Chapter 5**).

4.5 Taking action on public health care fees after 1994

4.5.1 The actors and processes involved in speedy fee removal

In President Mandela's first speech to parliament as President of the new Government of National Unity (GNU) on 24th May 1994, he announced a series of 'Presidential Lead Programmes' representing the GNU's top priorities for its first 100 days of office. Drawn from the RDP but with inputs from all departments, the speech included the announcement of free health care for pregnant women and children under six to become effective on 1st June 1994. In practice, however, the legislation for the policy only came into effect in July 1994 (Government Gazette, Notice 157 of 1994). The speed of the announcement took everyone by surprise and, although the new national Minister of Health did discuss it with provincial counterparts there was little time for careful planning of its implementation.

The decision was taken before the establishment of the Health Care Finance Committee in 1994. Nonetheless, this Committee was charged with developing fee proposals for the new government. Drawing both on further analysis of relevant international experience as well as on South African evidence of the very small contribution made by primary care fees to total revenue (McIntyre 1994b; McIntyre *et al.* 1995), the Committee affirmed the proposals of the ANC's Health Plan. It recommended that primary care services should be free at the point of service – proposing no charge for those who were uninsured but allowing costs to be recovered from those with insurance (Health Care Finance Committee 1994). The 1995 Committee of Inquiry into a National Health Insurance system (South Africa 1995) also made similar recommendations. Finally, the Minister announced the second free care policy, free primary care for all South Africans, in a parliamentary budget debate in April 1996.

Despite the findings of an evaluation of the first free care policy (McCoy 1996), and against the recommendations of the Health Care Finance Committee, the policy was again implemented speedily and with little prior consultation with managers or service providers. Although the policy was discussed and agreed in the PHRC (interview data), for other managers within provinces the announcement "*was very abrupt, very sudden and the provinces didn't have time to position themselves*" (provincial official, interview data). In practice, provinces responded in different ways in reflection of their own contexts and approaches. Western Cape strongly objected whereas Kwa Zulu Natal and Northern province were happy to implement it immediately (the first because of the security problems associated with fee collection, the second because it had little capacity to collect funds). Meanwhile, the Free State undertook a careful, but speedy, process of consultation within the province to support implementation (interview data).

4.5.2 Slow change in hospital fee schedules

Sketchy proposals on hospital fees were also part of the ANC Health Plan and hospital fee issues were re-considered both by the Health Care Finance Committee in 1994 and again within the context of the Hospital Strategy Project (HSP) in 1995/96.

All three sets of proposals included consideration of fee levels, as well as how to differentiate fees by patient income level (particularly considering the fee level to be charged to insured patients using public hospitals) and procedures for retaining fee revenue at hospital level. A specific obstacle facing the fee retention proposals, however, was that the existing Treasury regulations required revenue generated through health care fees to be returned to provincial revenue funds. The HSP proposals also included detailed recommendations on implementation procedures – such as the need for dedicated staff, for co-ordination across provinces and on the timing of key actions. In addition, its broader recommendations included wide-ranging proposals for strengthening hospital management to enable more efficient use of all available resources.

Within the HSP proposals the recommendation that fees should be simplified and differentiated by patient income level and facility type was specifically seen as a preparatory step towards an SHI system. The Project also recommended that fees should be tied to visible quality improvements to encourage payment and this, in turn, provided the basis for the proposal that ‘private wards’ with better hotel facilities than other wards should be opened to encourage use of public hospitals by medical aid patients. ‘Private patients’ could then be charged at full cost or higher rates, generating greater revenue than otherwise possible, whilst private wards would encourage medical staff from the private sector to work in public facilities (Monitor Company *et al.* 1996; interview data).

The slow progress in developing a national uniform hospital fee system was highlighted by one provincial health official in 1998. He commented then that there was “*more confusion on the fees than what there was before the HSP. Some provinces are not working on any system yet, some have ... not amended their fees since 1993, some provinces ... have sort of taken the old uniform fee system and amended it according to new policies like free health care, and then took some of the suggestions of the HSP ... But in some provinces, there’s just no system*” (interview data). However, the task team of the PHRC set to work on the issue in the later stages of the 1994-99 period was, ultimately, able to gain cross-provincial agreement for a re-structured hospital fee system. Implementation would only come after 1999. Similarly, although the 1997 White Paper on the Transformation of the Health System (Republic of South Africa 1997) identified general hospital management issues as critical in the broader transformation of the sector, little progress was made in bringing about such change between 1994 and 1999.

4.6 Working towards a policy agenda on N/SHI 1994-99

The four committees that considered N/SHI issues and the related question of medical scheme regulation (Table 4.1) might all be seen as rooted in the ANC Health Plan’s call for a Commission to “*examine the current crisis in (the) medical aid sector and to consider alternatives such as a compulsory National Health Insurance system*” (African National Congress 1994a: 77). This suggestion was also re-affirmed in the Health Care Finance Committee’s proposal that a “*technical commission of inquiry*” (Health Care Finance Committee 1994: 32) be established to undertake both technical analysis and to conduct a process of consultation with all relevant parties. The 1995 Committee of Inquiry might, therefore, be seen as a response to these calls, whilst its call for the creation of a technical committee to take forward its proposals was perhaps reflected in the establishment of the 1997 Working Groups.

Yet despite common roots and new bodies established out of the proposals of earlier structures, the experience of these committees was dis-jointed. They cannot be seen as a gradual process of smooth movement towards the development of N/SHI proposals. Instead, what the Health Care Finance Committee called the “*the economic and political arithmetic*” (Health Care Finance Committee 1994: 32) of deciding whether any N/SHI option would be

feasible led to the development of a series of policy proposals that changed in important ways over time. In addition, shaped both by the internal dynamics of the committees and external stakeholder concerns, the resulting policy development process can be characterised as a process of continual agenda setting.

4.6.1 The evolution of design in N/SHI proposals

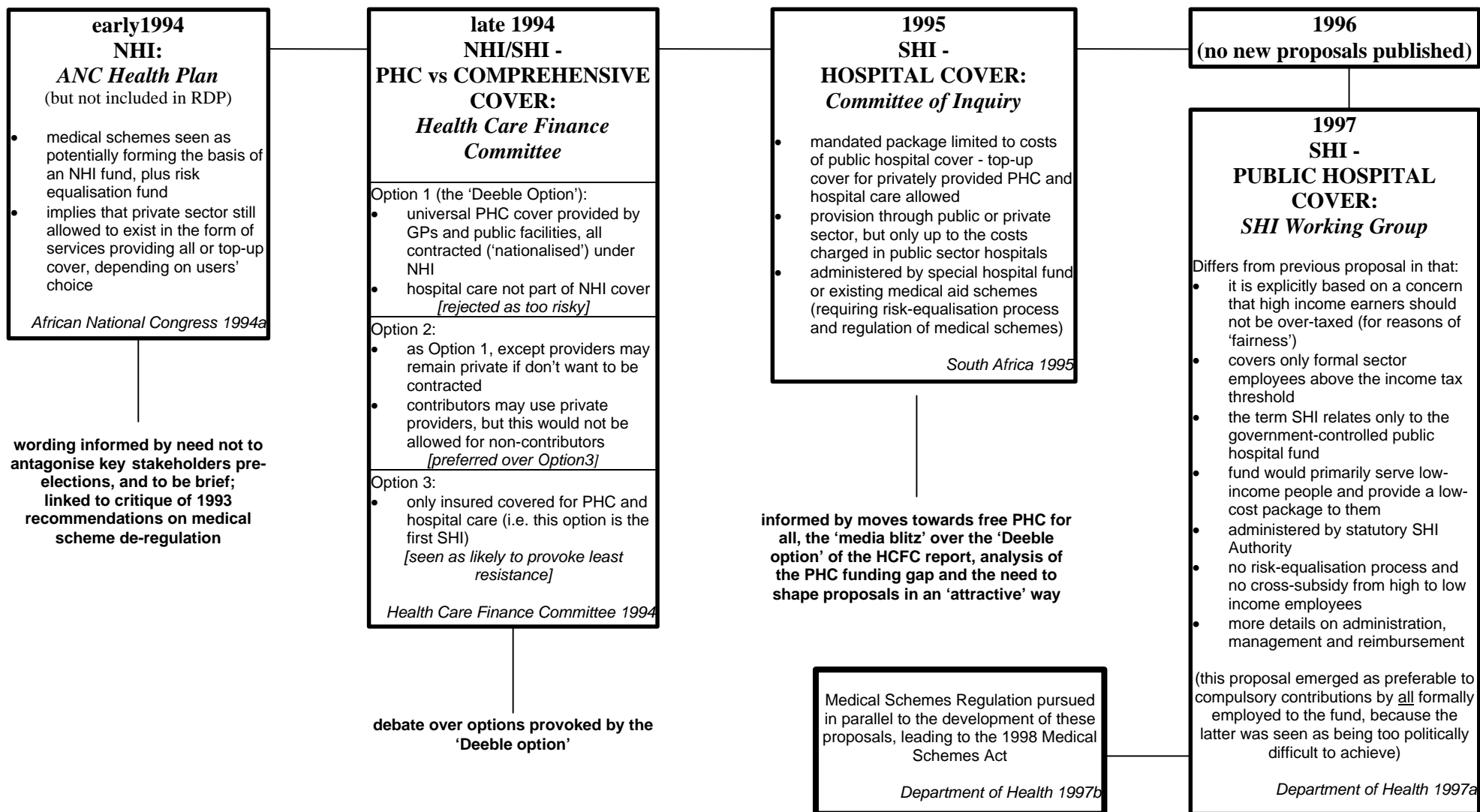
Building on the analysis and proposals of the pre-1994 period (section 4.2), the changing content of the N/SHI proposals over the 1994-1997 period is summarised in Figure 4.3.

Identified as a priority for policy development in the ANC Health Plan, the Health Care Finance Committee report then provided a more detailed consideration of three N/SHI options. These options were, in part, differentiated by the beneficiary group (the whole population vs. contributors only) and by what package of services would be covered through insurance (primary care only vs. a package of primary and hospital care). Ultimately, the Committee suggested that the option that was most feasible and least likely to provoke resistance would be an SHI scheme ensuring coverage of a package of primary and hospital care for contributors only (Health Care Finance Committee 1994). Picking up on this proposal but faced with the policy move towards free primary health care, the 1995 Committee of Inquiry proposed that the SHI scheme focus on the provision of hospital care only, to contributors only (South Africa 1995). Finally, the 1997 policy proposals limited the beneficiaries of a hospital only package to employees choosing not to take out health insurance cover, seeking specifically to target those on lower incomes. All the proposals, therefore, allowed for the sort of 'tiering' in hotel facilities within public hospitals also recommended in the Hospital Strategy Project, without discussing the potential that such differences might also lead to clinical care differentials. In addition, the 1997 proposals undermined previous attempts to ensure an SHI design that would allow cross-subsidisation between high and low income groups (Department of Health 1997a). They also dropped the 1995 plan to develop a 'risk equalisation' mechanism between existing private insurance schemes that would seek to spread the risk of providing cover across the entire insurance industry, and excluded the medical scheme industry as a candidate for administering the fund.

A further element of all post-1994 proposals was the role and functioning of the private sector, reflecting the pre-1994 emphasis on this issue. The proposals, firstly, incorporated quite different views on which providers would service the beneficiary population. The most radical proposal was the 'Deeble option' of the Health Care Finance Committee, which effectively proposed a nationalisation of private general practitioners in the move towards universal primary care coverage. In contrast, the 1997 proposals envisaged that the beneficiary population, the insured, would be primarily served by public hospitals (inferring that these hospitals might be supported by a limited number of private hospitals contracted to provinces). All proposals except the Deeble option also envisaged that those who could afford it would be allowed to purchase services additional to the package covered through the insurance scheme, from the private sector ('top up' cover).

Secondly, the operation of the private insurance industry became the subject of the 1997 policy development process undertaken in parallel to SHI, the process that resulted in the 1998 Medical Schemes Act and regulations developed in 1999. Building closely on the proposals of the 1995 Committee of Inquiry, the 1998 Act sought to address a range of problems that included adverse selection, risk skimming and dumping patients whose benefits had been exhausted on the public sector.

Figure 4.3: Key stages of NHI/SHI proposals, post-election



4.6.2 The continual process of agenda setting

Although Table 4.1 provides details of the special committees that have considered N/SHI policy over the 1994-99 period it does not fully illuminate the experience of these structures. This is more clearly reflected by the nature of debate within them, the pressures placed on them from external agents and the continual re-appearance of universal primary care coverage as an issue within their deliberations.

The Health Care Finance Committee and the Committee of Inquiry were, thus, less concerned with technical analysis than with the internal politicking particularly associated with interventions from Dr Deeble. Deeble first introduced into the Finance Committee discussions the proposal that universal PHC cover could be achieved by contracting both private GPs and public facilities into a NHI scheme. Debates within the committee came to focus more on the pros and cons of the 'Deeble option' than on any other element of their analysis and work. *"He made a proposal and that sent the committee ... down what I thought was a dead end, or whatever, and they ended up with a whole lot of stuff and then at the next set of meetings when he wasn't there, we went through all of that and we chucked it out again, and we came back to our original thing"* (committee member, interview data). Despite other differences between them, the remainder of the Committee's membership united in their opposition to this proposal on the grounds that it was neither politically nor financially feasible in South Africa (interview data). However, their opposition was partially undermined by aspects of the committee's internal functioning – such as time pressures, limited meetings for debate, and a change in chair. Also, whereas Committee members certainly felt that Dr Deeble had direct access to the then Minister, and the Deeble proposals certainly appeared to be favoured by Dr Zuma, they never met with her to discuss their proposals (interview data).

Nonetheless, whilst the final report considered the 'Deeble option' it expressed a clear preference for a different option (Health Care Finance Committee 1994). However, the original terms of reference for the Committee of Inquiry ignored this recommendation in calling for a NHI scheme that would support universal PHC access (South Africa 1995). Even its name initially suggested to many that it was *"an implementation committee for the Deeble option"* (health policy analyst, interview data). Leaks of the Health Care Finance Committee's discussions and report – specifically of the Deeble option – then generated strong media criticism, particularly among the business media (Box 4.3). *"I would suspect that the Deeble option was the one that was very explicitly leaked because people were concerned that this was actually going to get pushed through ... so I think people wanted to stir up opposition"* (health policy analysts, interview data). This media blitz, together with the refusal of the Committee of Inquiry's newly appointed chair to accept the initial terms of reference, finally led to a looser task description that allowed it to investigate a wider range of financing options (interview data).

Box 4.3: Media reporting around the 'Deeble option'

- 'Zuma's Guidelines on NHI' **South African Medical Journal**. 1995. 85(2): 32: *A member of the Health Care Finance Committee told the SAMJ that several members of the Committee of Inquiry, including two of the three international advisors, were threatening to resign because of the narrow terms of reference. They had to keep to the essence of the Deeble report and into ways of implementing it*
- 'Media Creates Debate on NHI Fund' **South African Medical Journal**. 1995. 85(2)
- 'Plans for Revolutionary Health Care' **Weekly Mail and Guardian** December 15th 1994
- 'Health Debate Focus Shifts' **Business Day** January 3rd 1995
- 'The Socialist Option' **Financial Mail** January 13th 1995
- 'Free Health Facilities Will Become Available to All South Africans' **The Sowetan** January 18th 1995
- 'Zuma Extends Scope of Investigation Into New Health Care System' **Business Day** January 24th 1995

Although the question of health insurance was secondary to ensuring access to primary care in its final terms of reference, the Deeble option again became the initial focus of much of the Committee of Inquiry's debates. Technical analysis was deliberately used as a tool within discussions to counter the option (interview data). Estimates of the likely size of the 'PHC funding gap' under the Deeble option compared to the amount of revenue that could probably be raised were used to show that the option was simply not financially feasible (South Africa 1995; van den Heever *et al.* 1995; interview data). This conclusion then allowed the Committee to consider alternative ways of meeting the total sectoral funding gap. A further axis of debate within the Committee was between the Department of Finance representatives and other Committee members. The DOF representatives *"always seemed to be at loggerheads with the rest of the committee but quite often it was purely saying that the DOF is not going to buy that, it's just not going to buy that"* (committee member, interview data). They were particularly concerned that some of the health care financing approaches considered as options for tackling the funding gap, such as a dedicated payroll tax, would be inconsistent with policy. At the same time, concern for the potential of private sector opposition to SHI proposals led to a broad process of consultation at several points with private sector actors. In contrast, Committee members were again not given the opportunity to meet or discuss their proposals with the Minister of Health.

Despite the debates and problems during the Committee of Inquiry, by its conclusion it was generally thought that *"Deeble was quite defeated"* (committee member, interview data). Yet the 1997 SHI Working Group was again initially tasked by the Minister with re-considering some of the elements of the earlier Deeble proposals (interview data). And again, although Deeble *"was also going and having private discussions with the Minister ... In many ways reporting his own interpretation of what the working group was saying"* (interview data), the technicians followed previous patterns by never meeting with Dr Zuma. Instead, having sought to remove 'Deeble-type' issues from the policy agenda through technical argument, the technicians returned to their primary task. In developing their detailed design proposals for a public hospital insurance mechanism they gave particular attention to the potential for DOF opposition to a proposal that could be seen as an additional tax (interview data).

In the end, however, although agreed in the health MINMEC, no action was taken on the SHI Working Group's proposals. Yet, in parallel, complex changes to the legislation governing the private insurance industry were guided into legislation by a small technical team (the 1997 Medical Schemes Working Group) that ultimately gained the support of the Minister. Following the development of necessary regulations in 1999, the changes will come into effect in 2000. In contrast, by 1999 health insurance was still being considered within the context of a comprehensive approach to social security reform linking pensions, unemployment pay and health insurance, following a policy line agreed at the December 1997 ANC Conference (interview data). It appears that the three critical opponents to the 1997 proposals were the then Minister of Health, the Department of Finance and, perhaps emerging from behind the scenes, the Congress of South Africa Trade Unions (interview data). The continued importance of social health insurance as a policy priority is, nonetheless, shown by its inclusion not only in the 1997 White Paper on the Transformation of the Health System, but also within the 1999 ANC election manifesto.

4.7 Summary: health care financing reforms 1994-99

The chronology of the policy development process in each reform area between 1994 and 1999 is summarised in Figure 4.4 and Table 4.3. As is illustrated, although the ANC Health Plan laid out a policy agenda in all areas, the pattern of policy development after 1994 differed in four important ways between them.

First, the speedy ‘policy actions’ of creating a health sector resource re-allocation formula and the removal of some public care fees was in direct contrast to the slow progress on public hospital fees and to the uneven process of ‘agenda-setting’ for N/SHI. By 1999, there had been no implemented change in either policy area.

Second, although initial policy action on both fees and resource re-allocation occurred speedily, the nature of the processes through which these actions were implemented differed. Fee removal involved two special ‘one-off’ policy actions – taking advantage of a particular window of political opportunity and involving only some consultation with a limited group of actors. In contrast, the necessary implementation of resource allocation policy through the routine government budgeting process required increasing degrees of consultation over the years and had to respond to the evolution of these processes over time. The initial ‘one-off’ policy action of implementing a health sector formula in pursuit of financial equity was, therefore, overtaken by the move towards fiscal federalism - which led to the need for new policies with the same objective that could take effect within a changed policy environment. In this new environment, policy development for the health sector has been much slower than in the earlier period. By 1999 little progress had been made in developing and applying norms and standards to influence resource allocations.

Third, changes in resource allocation practice developed during the fiscal federal era may have evolved only slowly but such changes were, like the Function Committee proposals, almost immediately implemented through the routine budgetary process. In contrast, the slow development of N/SHI policy through various special structures led to policy proposals but no policy change.

Fourth, although initially seen as part of the same policy package, the development of SHI proposals became divorced from the development of private insurance regulation proposals in 1997. The two processes had quite different results. The 1997 SHI Working Group generated a MINMEC-approved set of proposals but these remained the subject of continuing policy debate after then. In contrast, the work of the Medical Schemes Working Group led to the development of new legislation in 1998, a clear policy change.

These broad patterns of policy development and the differences between them prompt three sets of questions for further investigation:

- what impacts did the implemented policy changes have on the equity and sustainability problems of the health system, and how did the design of the reforms influence these impacts? (see **Chapter 5**);
- would the various SHI proposals have helped to tackle the remaining equity and sustainability problems of the health system, and, if so, how? (see **Chapter 6**);
- what factors explain both the nature of policy design and the pattern of policy development and implementation within each policy area as well as the differences between the policy processes of focus, and how did these diverse factors shape the actual or potential impact of the reforms investigated? (**Chapter 7-9**).

Figure 4.4: The chronology of health financing policy development in South Africa, 1994-99

	1991	1992	1993	1994	1995	1996	1997	1998-9
RESOURCE ALLOCATION (occurring within routine budget process)				<i>FUNCTION COMMITTEE ERA</i> Health Formula developed & applied				
						<i>ERA OF FISCAL FEDERALISM</i> Provincial Unconditional Block Grants with phased introduction of health conditional grants		
USER FEES				Free Care 1				
	hospital fee policy debated and developed > > >					Free Care 2	> > >	
						HSP hospital fee proposals		
HEALTH INSURANCE	debates about the merits of a national health system versus national health insurance system				debates over nature of 'social' health insurance			
								1998 Medical Schemes Act
SPECIAL POLICY PROCESSES			<i>ANC Health Plan Development</i>	<i>Health Care Financing Committee</i>	<i>Committee of Inquiry</i>		<i>SHI Working Group</i>	
					<i>Hospital Strategy Project (HSP)</i>	<i>Medical Schemes Working Group</i>		
Key: bold = policy change implemented; not bold = policy change not implemented; italics = processes;								

Table 4.3: The evolution of health financing reform			
YEAR	REFORMS OF FOCUS		
	RESOURCE ALLOCATION	PUBLIC CARE FEES	N/SHI
late 1980s – early 1990s	<i>Towards an agenda:</i> analysis of geographic inequities; SAHRA proposal <i>Policy action:</i> Function Committee process		<i>Towards an agenda:</i> NHS vs. NHI debates
early 1990s-1994	<i>Agenda setting through ANC health plan development:</i> • makes proposals across all reform areas		
1994	<i>Policy actions:</i> Function Committee establishes policy for health resource re-allocations across provinces in 94/95 budget	<i>Policy actions:</i> Free care 1	<i>Agenda setting/policy formulation:</i> HCFC presents three N/SHI options; recommends that wider Commission be established to take forward policy development
1995	<i>Policy implementation:</i> Function Committee continues with revision & application of formula for 95/96 fy	<i>Agenda setting:</i> Minister of Health budget speech accepts principle of universally accessible PHC	<i>Agenda setting (policy formulation?):</i> negative reactions in press to leaked 'Deeble option' of HCFC; COI recommends establishing committee to develop greater detail of SHI & medical scheme re-regulation
1996	<i>Policy implementation:</i> application of health formula for 96/97 fy; era of fiscal federalism brings unconditional block grants for provinces from 97/98 fy <i>Policy formulation:</i> health conditional grants established to be applied from 1997/98 fy	<i>Evaluation:</i> of Free care 1 published <i>Policy action</i> Free care 2 <i>Policy formulation:</i> HSP hospital fee proposals published	<i>Policy formulation:</i> Medical Schemes Working Group established
1997	<i>Policy implementation/formulation:</i> evolution of health conditional grants; MTEF introduced for 98/99 fy; health MTEF task group established; continued development of formula for determining unconditional block grants;	<i>Policy formulation:</i> continued discussion of hospital fee issues in PHRC	<i>Agenda setting:</i> White Paper on the Transformation of the Public Health System published endorsing SHI; SHI Working Group established; SHI Working Group publish proposals <i>Policy formulation:</i> Medical Schemes working group meeting
1998	<i>Policy implementation/formulation:</i> evolution of health conditional grants; health '4x4' initiated; continued development of MTEFs and formula for determining unconditional block grants;	<i>Policy formulation:</i> continued discussion of hospital fee issues in PHRC (and task team)	<i>Agenda setting/policy formulation:</i> initial discussion on development of social security including SHI <i>Policy implementation:</i> passing of Medical Schemes Act
1999	<i>Policy implementation/formulation:</i> evolution of health conditional grants; continued evolution and application of unconditional block grants	<i>Policy formulation:</i> continued discussion of hospital fee issues in PHRC (and task team)	<i>Agenda setting/policy formulation:</i> social security discussion continuing; publication of ANC manifesto endorsing SHI importance <i>Policy implementation:</i> regulations to implement developed
<p><u>Abbreviations:</u> ANC = African National Congress COI = Committee of Inquiry HCFC = Health Care Finance Committee Free Care 1 = free care for nursing mothers and children under six Free Care 2 = free primary care fy = financial year MTEF = medium term expenditure framework NHI = national health insurance NHS = national health system PHC= primary health care PHRC = provincial health restructuring committee SAHRA = South African Health Resource Allocation SHI = social health insurance</p>			

Annex 4.1: Details of resource allocation formulae, South Africa 1994-99

Box A: The Health Function Committee's resource allocation formula

1. The 'top-slice' deducted from the total health allocation for services and activities that were of national benefit included:

- The allocation for the national Department of Health;
- An allocation for training, research and specialised referral services by Academic Health Centres , *estimated to be 25 percent of the total budget of provinces with Academic Health Centres*;
- An 'equalisation fund' of R166 million to fund the recurrent costs of clinics that were to be built using RDP and donor funds.

2. Provincial health allocations came from the budget remaining after the 'top-slice' and were determined on the basis of a 'need-based' formula, which had two main components:

- A target provincial percentage budget allocation was estimated as

$$\% \text{ of health budget (after 'top-slice')} = (\text{Nominal weighted provincial population} / \text{Total nominal weighted population}) \times 100$$

where *the nominal weighted population* = *actual population* + $(0.25 \times \text{actual population} \times \{\text{national per capita income} / \text{provincial per capita income}\})$

In effect, this formula estimated the proportion of the 'weighted' population within each province, where the population is weighted by an indicator of disparities in per capita income (i.e. provinces with lower per capita incomes would receive a higher weighting as they were likely to have a higher proportion of their population dependent on public sector health services).

- The target budget allocation for each province was then calculated as *target % allocation x total health budget after 'top-slice' deducted*. This was compared with the estimated actual expenditure per province in 1994/95 (excluding 'top-slice' expenditure items). It was determined that provinces should reach their target allocations within 5 years, but that 30 percent of the redistribution should occur in the 1995/96 financial year.

3. Changes to the 1996/97 formula

In the 'needs-based' formula provincial populations were no longer weighted by the per capita income indicator. Instead, the medical scheme membership within each province was estimated, and the nominal population adjusted for lower usage of public sector health facilities by medical scheme members.

Sources: Doherty and van den Heever 1997; McIntyre 1997a.

Box B: Components of the Department of Finance formula underlying the 'horizontal division' (i.e. allocation of unconditional block grants to provinces)

1. Initial formula

$$\text{Provincial share} = 0.39E + 0.18H + 0.16SW + 0.15B + 0.08EO + 0.04I$$

where:

- E = Education component which is based on the average of the size of the school-age population and the number of learners actually enrolled (weighted by 39%)
- H = Health component which is based on the proportion of the population without private health insurance and weighted in favour of women, children and the elderly (using estimated utilisation differentials) (weighted by 18%)
- SW = Social welfare component which is based on the estimated number of people entitled to social security grants (elderly, disabled and children – these three components were weighted to reflect the relative size of the different social security grants; old age pensions – 65%, child and family care – 10%, disability and other grants – 25%) (weighted by 16%)
- B = Basic component which is based on the total provincial population with a 50% weighting for rural residents (as a proxy for socio-economic status and the existence of backlogs) (weighted by 15%)
- EO = Economic output component which is based on the estimated provincial Gross Geographical Product (as a proxy for own revenue within provinces – it directs a proportion of nationally collected revenue back to the provinces where they were generated) (weighted by 8%)
- I = Institutional component, for which each province receives the same amount, is based on the cost of maintaining public administration, building essential capacity and participating in intergovernmental forums (weighted by 4%)

The weights assigned to the education, health and social welfare components were based on the percentage of overall provincial spending on these services. The DOF recommended moving towards equity target allocations over a 5-year period.

2. Subsequent changes

- introduction of 'backlogs' component to take account of differing needs for rural infrastructural development between provinces
- for health component: estimated proportion of population with private health insurance included but with lower weighting than rest of population; weighting for women, children and elderly removed
- removal of rural weighting in determination of 'basic component' (as included in backlog factor), so basic component weighted only by size of each province's population
- changes in the weighting given to some of the original components: to the education component (from 39% to 40%), the social welfare component (from 16% to 17%), the basic component (from 15% to 9%) and the institutional component (from 4% to 5%).

Sources: Department of Finance 1998b, 1999.

CHAPTER FIVE UNDERSTANDING THE IMPACT OF FINANCING POLICY CHANGES	65
5.1 Assessing impact	65
5.2 Assessment of resource allocation policies	66
5.3 Assessment of free care policies	77
5.4 Summary and conclusions	80

CHAPTER FIVE

UNDERSTANDING THE IMPACT OF FINANCING POLICY CHANGES

This chapter draws together the available evidence on the impact on health equity and health system sustainability of the health care financing changes implemented in the 1994-99 period, that is resource re-allocation and the removal of user fees. It then seeks initial explanations for the identified impacts in the design of the policies and the linkage between these reforms and parallel, institutional change. Further conclusions and recommendations derived from this analysis are presented in Chapter 10. Finally, analysis of the factors influencing design is presented in Chapters 7-9.

5.1 Assessing impact

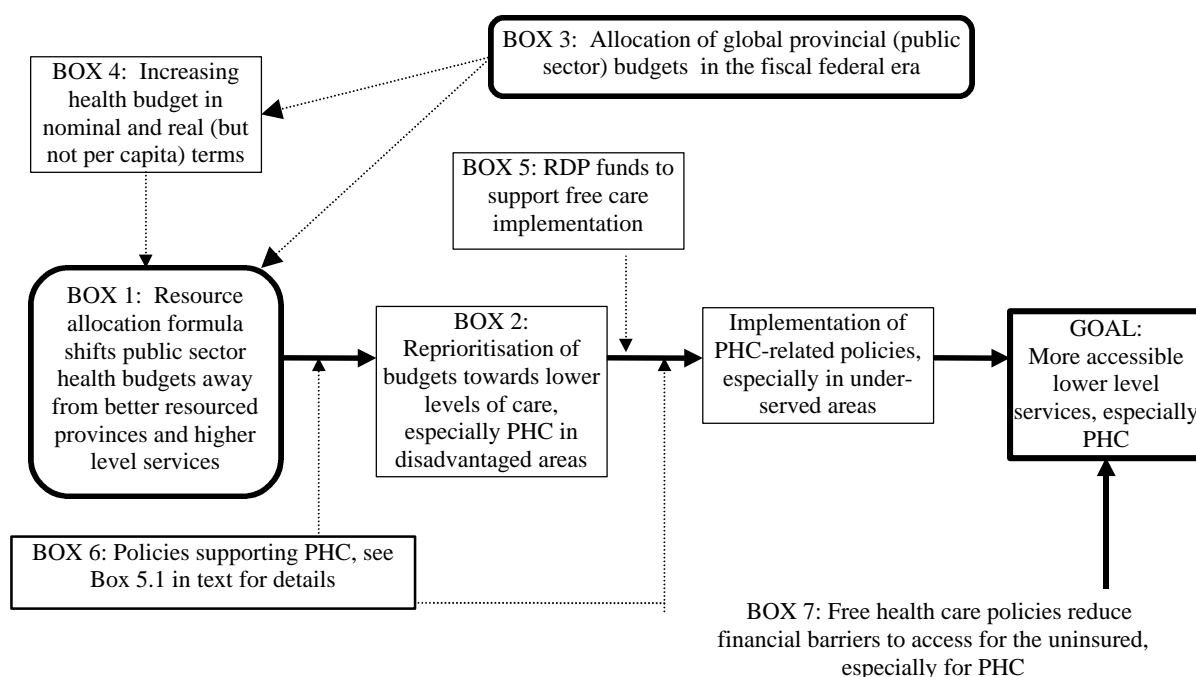
Judgements about a reform's impact obviously have to be made within the context of the reform's stated objectives. As identified in **Chapter 2**, the two financing reforms that had been implemented by the Department of Health by 1999 - the removal of user fees for various services, and the use of a needs-based formula to distribute the health budget between provinces - both had the achievement of equity as their prime objective. They sought to remove financial barriers to health care in the first instance, and distribute public sector financial resources equitably in the second. Allocative efficiency was also an objective of the Function Committee's health sector resource allocation formula, in that it intended to shift resources to lower levels of care. However, this objective was a less explicit one. Also, in the South African context where high level facilities are concentrated in a few, urbanised areas, it was integrally linked to the notion of equity, requiring as it did a shift in spending between provinces. Both reforms were, thus, key to achieving the vision of The White Paper for the Transformation of the Health System in South Africa which, responding to the inequities and fragmentation of the apartheid health care system, sought to establish a single, unifying health system that would co-ordinate activities in the interests of equity, placing special emphasis on 'reaching the poor, the under-served, the aged, women and children, who are amongst the most vulnerable' (Republic of South Africa 1997: 13).

As identified in **Chapter 4**, assessment of the impact of resource allocation policy in the 1994-99 period also requires consideration of the consequences of new budgeting and allocation procedures introduced in the fiscal federal era. Although not a health sector policy action, the impact of the Department of Finance formula for allocating the total pool of provincial resources on the pattern of inter-provincial health sector resource allocations is, therefore, also considered here.

It is notable that health system sustainability was not a clear concern of any of the reforms of focus (see **Chapter 2**). Yet, as **Chapter 3** indicated, both the public and private health care sectors faced many challenges to long-term sustainability when the first democratic government came to power. If anything, these challenges have increased as HIV, which is estimated now to infect one in every eight adults, begins to take its toll on health services (Department of Health 1998). Hence, this chapter judges the extent to which the reforms both reduced the inequities experienced under the apartheid regime *and* improved the long-term sustainability of the health system. The discussion is built around Figure 5.1 that shows the routes through which reforms studied had the potential to tackle the problems inherited from the past. The reforms of focus are identified by boxes with dark edges and rounded corners, with other boxes representing the parallel policy changes that influenced these reforms' impact.

The data sources used in this chapter are pre-existing evaluations, interviews with key informants and press reportage. As explained in **Chapter 2**, no primary data collection was undertaken by the project.

Figure 5.1: The routes through which the health care financing reforms of focus had the potential to tackle inherited problems (solid lines), and be supported in this by other policies (dotted lines).



5.2 Assessment of resource allocation policies

In the interests of equity, the first democratic government began re-allocating the public health budget between provinces within its first year in office. As indicated in **Chapter 4**, this process was initially led by the Health Function Committee (Box 1, Figure 5.1) and was also associated with the specific objective of re-allocating budgets towards PHC (Box 2, Figure 5.1). However, with the transition in 1997/98 to global budgeting for provinces under the system of fiscal federalism, control by the DOH over the reallocation process all but evaporated, except for its residual influence over the calculation of conditional grants (identified as Box 3, Figure 5.1). As these two phases of resource allocation impacted differently on budgetary shifts in the health sector, they are discussed separately below.

5.2.1 The geographic re-allocation of resources through the Health Function Committee process

Figure 5.2 shows that, in 1995/96, two provinces – the Western Cape and Gauteng - were well-resourced in comparison to other provinces¹. Two others – the Free State and KwaZulu-Natal – were spending close to the national per capita average, the former a little above, and the latter a little below. The remaining provinces were spending well below the national average. This pattern remains the same, even when expenditure on academic hospitals is omitted (see Figure 5.3). Per capita expenditure analyses are limited in their usefulness in measuring progress towards equity as they do not adequately capture the relative need of different populations. However, Figures 5.2 and 5.3 are interesting in that they show that the DOH formula used in 1996/97 was successful in shifting public spending in most provinces in the direction of the national average per capita level. Nevertheless, in three provinces - Mpumalanga, North West, Northern Cape and Free State - it appears to have slightly worsened the position in relation to equity (as measured by per capita public expenditure), while in the Free State it completely reversed the position of the province, moving it from a situation of excess per capita expenditure to one of deficient per capita expenditure. As discussed later, this was due to changes in the design of the formula.

These inter-provincial shifts were achieved partly because the overall health budget, as a proportion of total government expenditure, was in the process of increasing from its level of 10 percent in 1995/96 to its MTEF target of 11 percent by 2000/01 (Box 4, Figure 5.1). Thus, unlike some of the other government departments, re-distribution in the public health sector occurred without having to also implement widespread cut-backs due to shrinking budgets. Indeed, within provinces, approximately 20 percent of provincial budgets was consistently put aside for health care (once the costs of academic hospitals, which are seen as national assets, have been excluded) (McIntyre *et al.* 1998). Despite these favourable circumstances, public health spending hardly kept pace with population growth rates. As McIntyre *et al.* (1998) calculated, real per capita public sector health care expenditure was R516 in 1995/96 and was expected to decline slightly (to R512) by 2000/01. Yet per capita expenditure requirements will increase as a result of the rapidly expanding HIV/AIDS epidemic.

5.2.2 Re-prioritising resources for lower levels of care through the Health Function Committee process

The DOH systematically attempted to re-prioritise public health spending towards lower level services over the 1994-99 period. PHC services, in particular, were seen not only as more cost-effective than higher level care services (Republic of South Africa 1997), but also as the main vehicle through which health care could be brought to the doorstep of South Africans under-served during the apartheid era. Financial re-prioritisation was effected mainly by the Function Committee resource allocation formulae of 1995/96 and 1996/97 which, in consciously cutting budgets in provinces with academic hospitals, attempted to shift funding away from higher level services. This shift was supported in the same years by allocations from the RDP that were intended to fund the increased physical and human resources required to meet the increased demand expected to result from free health care (Box 5, Figure 5.1). Financial re-prioritisation was complemented by an array of policies intended to re-organise other resources, such as facilities, personnel and drugs, in favour of lower level services (Box 6, Figure 5.1, see also Box 5.1 below).

¹ The figures for 1995/96 and 1996/97 represent actual expenditure, while the figures for 1997/98 onwards represent budgets. The population data used to determine per capita expenditure/budget estimates in these figures exclude those people with medical scheme coverage, in line with accepted practice in South Africa.

Figure 5.2: Percentage difference between total real per capita provincial health expenditure (1995/96 & 1996/97) and budgets (1997/98-2000/01) and the national average (Source: McIntyre *et al.* 1998)

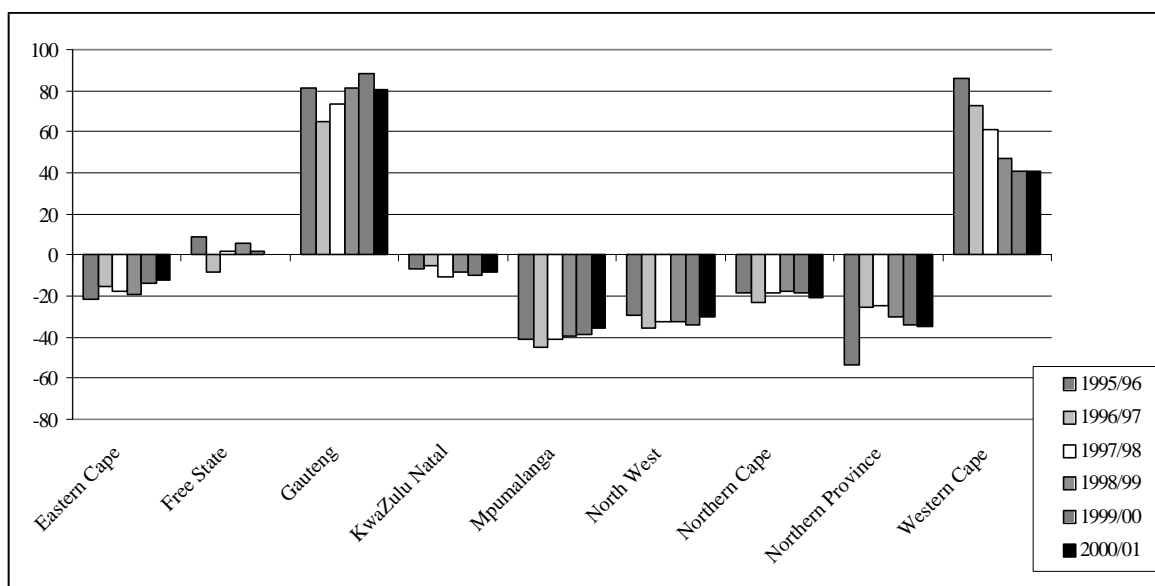
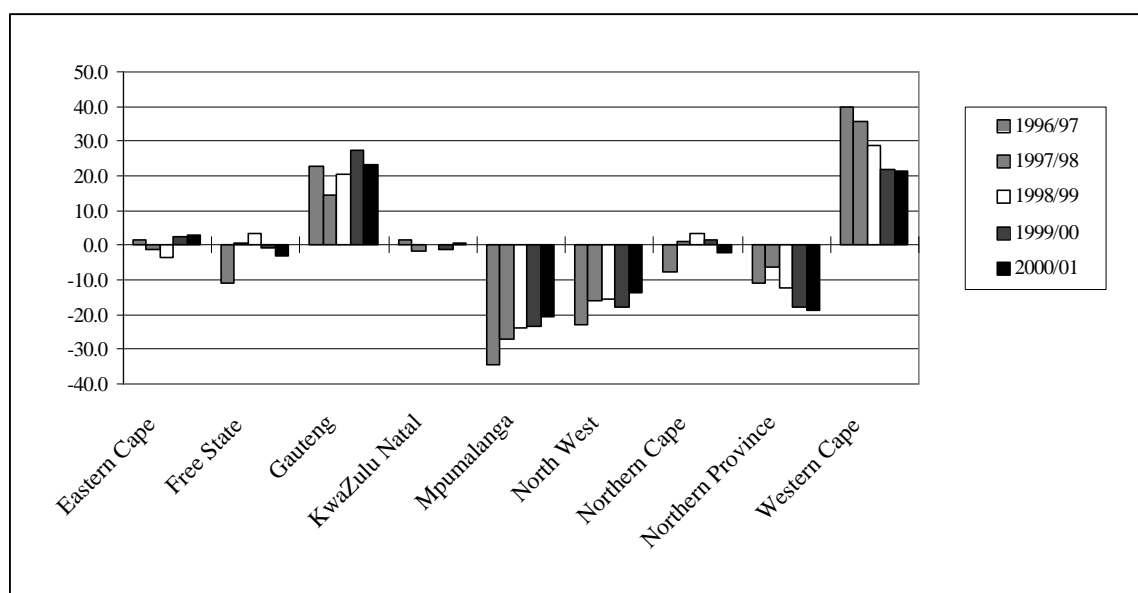


Figure 5.3: Percentage difference between real per capita provincial health expenditure (1995/96 and 1996/97) and budgets (1997/98 - 2000/01) (excluding academic hospitals) and the national average (Source: McIntyre *et al.* 1998)



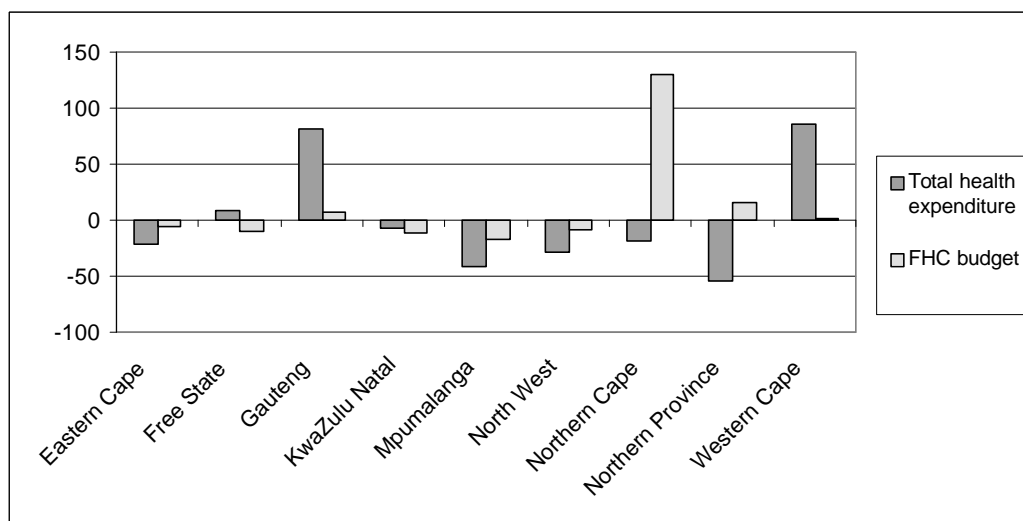
Box 5.1: The main policies supporting re-prioritisation of spending on lower level services

1. **The development of a District Health System** through which to implement PHC.
2. **The development of PHC facilities** in under-served areas, especially through the Clinic Upgrading and Building Programme initiated in 1994.
3. **The deployment of doctors** to under-served, often rural communities through the recruitment of foreign doctors (particularly from Cuba) from 1996 and mandatory community service for medical doctors following graduation from 1998.
4. **Encouragement of improved drug distribution and use** through the distribution in 1996 of an essential drugs list and standard treatment guidelines for primary care facilities, and improvement of the procurement and distribution of drugs through the restructuring of COMED (the state organisation charged with this responsibility) or the contracting of private organisations to take over these activities.

The extent to which the formulae were able to shift funds towards lower level services in practice is, however, unclear because of problems in dis-aggregating and comparing data in a consistent fashion across the years. De Bruyn *et al.* (1998) conclude that expenditure on non-hospital PHC services doubled between 1992/93 and 1997/98. While these shifts were relatively modest - and mainly represented the re-distribution of existing budget funds rather than resulting from additional revenue - they made a major difference, at least in the early years, to historically disadvantaged provinces (interview data). Accompanying this financial re-prioritisation was the extension of PHC facilities through the auspices of the Clinic Upgrading and Building Programme, which gained prominence as a Presidential Lead Project of the RDP. Govender and McIntyre (1997) report that over 60 percent of the 295 clinics planned for Phases 1 to 3 of the programme (which concluded at the end of the 1996/97 financial year) were intended for the three provinces deemed in most need. They also report an effort to target the poorest communities with the worst access to facilities, which translated into 62 percent of clinics being planned for the poorest 40 percent of districts. As an interviewee working in one of the poorest provinces noted, '*For the first two years it was the land of milk and honey*'.

McIntyre *et al.* (1998) are more cautious, however, suggesting that whilst there was some change in the proportion of overall provincial health budgets devoted to district health services, per capita budgets for district services stagnated, or may even have declined, as a result of population growth, inflation and a stagnating health budget. Within this climate, the lack of new sources of funds for PHC development is worrying. While the RDP allocations in 1995/96 attempted to ameliorate this problem, the allocations were small, representing 4.1 per cent of total public health expenditure in 1995/96 and 3.2 per cent of budgeted expenditure in 1996/97. As Figure 5.4 shows, the way in which these funds was allocated between provinces did little to promote a relative distribution of resources in favour of historically disadvantaged provinces. If the RDP funds had been intended to promote equity, one would have expected relatively more resources to have been allocated to currently under-resourced provinces. However, while two of the poorer provinces benefited considerably, another four of the poorer provinces received an inequitably small share of RDP funds, and two of the better-off provinces received more than their fair share of the RDP funds.

Figure 5.4: Percentage difference between per capita provincial health expenditure (and provincial free health care budgets) and the national average



5.2.3 Design weaknesses of the Health Function Committee formula

Notwithstanding the equity achievements of this phase of resource allocation, there were several limitations to the design of the Health Function Committee formula. Various criticisms were levelled at the 1995/96 version in particular, based on extensive reviews of the international literature which established key criteria for an appropriate formula (Doherty and van den Heever 1997; McIntyre 1997a; McIntyre *et al.* 1995). Generated rapidly and without the benefit of much detailed analysis, the formula was consequently fairly crude in nature (see **Chapter 7**).

The three major concerns related to:

- the way in which special allocations (such as NITER, the National Increment for Training, Education and Research) were calculated;
- the method of estimating relative need for health services; and
- the pace of redistribution.

The NITER component earmarked 25 percent of the previous year's estimated health care expenditure in each province containing academic hospitals for training, research and highly specialised services (see **Chapter 4**). However, provinces such as Gauteng and the Western Cape devoted considerably more than 25 percent of their budget to these services (for example, 45 percent of the Western Cape's 1995/96 health budget was attributable to these hospitals (Strachan 1995)). Other provinces such as KwaZulu-Natal have a relatively low concentration of resources in academic hospitals (McIntyre *et al.* 1995). The application of an arbitrary percentage uniformly across all relevant provinces translated into massive budget cuts for those provinces containing the major academic hospitals (for example, the Western Cape's budget was cut by nearly 19 percent in real terms). Critics argued that provinces should be funded in relation to their relative contribution to training, research and provision of highly specialised services and that such funding should be based on the actual costs of these activities (Doherty and van den Heever 1997). This is in line with approaches used internationally – such as the deliberations of the English Resource Allocation Working Party (RAWP), reported in Department of Health and Social Security (1976; 1986).

The Function Committee's initial use of total provincial population weighted by per capita income as an indicator of relative need for health services was also criticised. Based on a review of the international literature to determine the types of indicators of need adopted in different countries using resource allocation formulae (Doherty and van den Heever 1997; McIntyre 1997a; McIntyre *et al.* 1995), it was argued that:

- the population data used were likely to be inaccurate² and did not take account of differential population growth rates in provinces (both through different birth and death rates and as a result of migration patterns);
- the population with access to private sector services should be deducted from the total provincial population, as the goal of the formula was the equitable allocation of public sector health care resources and the public sector was intended to serve only the uninsured population (this recommendation was adopted by the Health Function Committee in its second version of the formula in 1996/97);
- the age and sex distribution within provinces should be taken into account (as these demographic variables influence the relative need for health services); and
- more direct indicators of health service need than per capita income (such as mortality data) should be incorporated.

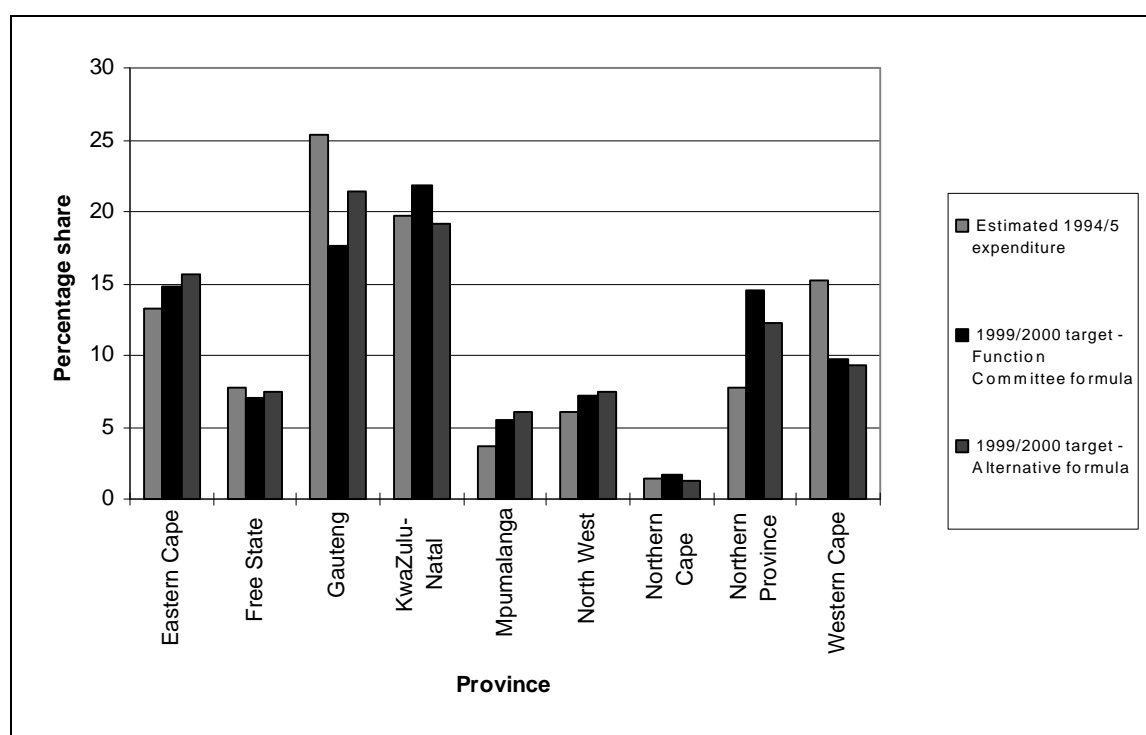
The Function Committee's formula also specified that redistribution to achieve equitable allocations should occur over a five-year time frame, with 30 percent of the redistribution occurring in the first year (as noted in **Chapter 4**). This translated into real budgetary changes between 1994/95 and 1995/96 ranging from a decrease of 18.6 percent in the Western Cape to an increase of 17 percent in the Northern Province (Doherty and van den Heever 1997). These rates of change were considerably faster than adopted in other countries attempting to effect a geographic redistribution of resources. For example, the English RAWP recommended a ceiling of 5 per cent real growth over the previous year's allocation and a floor of 2.5 percent reduction in real budgets (Department of Health and Social Security Services 1976). There were concerns that the very rapid redistribution would not allow those provinces faced with large budget cuts to plan appropriately for downscaling services and that existing services would be irreparably harmed. Conversely, provinces that gained from the reallocation process were unlikely to develop additional health service infrastructure, and thereby adequately absorb increased recurrent budgets, at the pace required to achieve equity within five years (Doherty and van den Heever 1997; McIntyre 1997b; McIntyre *et al.* 1995). In the event, RDP bridging finance was ultimately sought to assist the Western Cape and Gauteng in coping with the downscaling of academic hospitals as it became apparent that they were unable to absorb such significant annual real budget cuts (interview data).

For these reasons, the design of the Health Function Committee formula had profound implications for the distribution of the health budget between provinces. To demonstrate the effects of design on budget allocations, Figure 5.5 shows the difference in the equitable target budget allocations to each province based on the Health Function Committee's formula and an alternative formula (developed by Doherty and van den Heever (1997) that used different

² While it was universally recognised that the official population estimates were unreliable, there was a range of alternative population estimates that had been adjusted for estimated undercounting and used alternative population growth rate estimates. There was considerable debate about which of these alternative data sets were likely to be most accurate. The Function Committee opted to use the Development Bank of Southern Africa (DBSA) data set while Doherty and van den Heever (1997) argued that the Demographic Information Bureau (DIB) data-set was more accurate. When comparing the DBSA and DIB estimates with the final 1996 census estimates, both the DBSA and DIB data-sets significantly underestimated the Western Cape and overestimated the Eastern Cape population. For the other seven provinces, the DBSA data-set more accurately reflected the final census estimates in two provinces, while the DIB data-set was a more accurate reflection of the remaining five provincial populations. This suggests that, on balance, the DIB data set was a more accurate reflection of the population distribution, but was still deficient in some respects (see also Table 5.2).

indicators of need and a different population data-set. The Figure also compares these different targets with the estimated provincial health care expenditure in 1994/95, to highlight the implications of the alternative targets for each province. For example, Gauteng experienced massive budget cuts based on the Function Committee formula (which suggested that Gauteng's share of health resources had to drop from 25.4 percent to 17.6 percent). Gauteng's budget cuts were approximately twice as great as they would have been if the alternative formula had been used.

Figure 5.5: Comparison of estimated 1994/95 provincial expenditure with target allocations based on the Function Committee and Doherty and van den Heever (1997) resource allocation formulae (% share of total provincial health care expenditure/budget)



Source: Doherty and van den Heever 1997.

While any resource allocation formula is likely to generate debate and draw criticism, especially from those who stand to lose the most, developing an appropriate and widely acceptable formula from the outset was particularly important given the very rapid pace of recommended budgetary redistribution in South Africa. Expressed differently, if one is attempting to effect a dramatic redistribution of resources over a short period of time, it is essential that the direction and magnitude of desired change are correctly estimated lest one go in the wrong direction or 'overshoot the mark'. Figure 5.5. indicates that while KwaZulu-Natal's share of the budget was being increased on the basis of the Function Committee's formula, the alternative formula suggested that its share should possibly have been declining. In most other cases, the *direction* of redistribution was the same irrespective of the design of the different formulae, but the *magnitude* of redistribution may have been excessive in the case of the Function Committee formula. It might even have led to a situation in which provinces experiencing large budget cuts downscaled their health service provision, only to gain additional funds and expand service provision some years later, once a different formula, with more detailed design in relation to indicators of need and using more accurate population and other data, had been developed (Doherty and van den Heever 1997; McIntyre *et al.* 1995). Such concerns about the '*excessive shifting of resources*' (McIntyre 1994c: 16) due to inaccurate population figures and inadequate consideration of differential population growth

rates between provinces, had been raised (see for example McIntyre 1994a; 1994c) before the Function Committee began its deliberations on a resource allocation process and formula.

A notable, additional consequence of the extent of redistribution was on the perceived quality of public hospital care, an issue picked up extensively in the media and prompting continued decline in public confidence in the hospital system (see Box 5.2). This impact was, however, also a result of the speed of change and lack of clear communication with front-line workers (see **Chapter 9**).

Box 5.2: Example of media headlines on public hospitals

The shame of Johannesburg Hospital:	The Star , 10/6/96
Gauteng hospitals need cash urgently:	The Business Day , 12/8/96
Health services are deteriorating fast:	The Business Day , 23/12/97
Hospital overcrowding may cause irreversible damage:	The Star , 29/1/98

5.2.4 The global provincial budgeting process

Once global budgeting was introduced, progress towards equity in the health sector, as measured by per capita public expenditure, slowed³. As Figures 5.2 and 5.3 show, the positive trends towards equity achieved by the Health Function Committee formula were generally destabilised by the advent of global budgeting, the exception being the Western Cape where a steady decline in spending towards equity has been achieved. Excess spending increased in two provinces (that is, the Free State and, more notably, Gauteng⁴). The remaining provinces (all of which are poor) saw earlier equity improvements reversed or halted.

An important reason for this trend was that the national and provincial health departments had not put mechanisms in place to promote an equitable distribution of health budgets once global provincial budgeting was implemented in 1997/98. The Health Function Committee (like function committees in other sectors) focused exclusively on distributing the global health budget for 1995/96 and 1996/97 between provinces, and gave little consideration to the implications of fiscal federalism. In addition, the evolution of fiscal federalism occurred within the context of a lack of clarity about inter-governmental relations in general (see **Chapters 3, 7**). However, even after global budgeting was implemented (at the beginning of the 1997/98 financial year), there still was only limited progress in developing mechanisms to promote the equitable allocation of health care resources in a fiscal federal environment. Instead, allocations to health care became subject to political jockeying between the different provincial departments competing for a share of the provincial global budget (see **Chapter 7**).

5.2.5 Important design issues in the era of fiscal federalism

Another explanation for the set-backs in health care resource allocation in the fiscal federal era lies in the design of the formula used to calculate global provincial budgets, that is to determine the 'horizontal division' of public resources (see **Chapter 4**). The design features of both the Financial and Fiscal Commission (FFC) and Department of Finance's (DOF) versions have, like the Health Function Committee formula, been the subject of considerable debate. There are many similarities between the individual components of the FFC and DOF formulae. One key difference is that the DOF alternative weights the various components of the formula. In the case of social services, the weighting is based on the current level of

³ These trends remain roughly the same even when academic hospitals' budgets are excluded from the analysis, the only difference being that the Eastern Cape, Northern Cape and KwaZulu-Natal appear to be nearer their equity targets.

⁴ In Gauteng the MTEF projections were set to increase its relative allocations even further over the following two years.

spending on these services. The main concern is that this reflects historical expenditure patterns rather than the perceived priority of the service. Thus, the Financial and Fiscal Commission (1998: 13) commented that “*it is not clear why the 39% weighting for education should remain at that level and whether the level is appropriate in the first place*”. It is interesting to note that, although provinces were required to devote 85 percent of their budgets to social services from 1998, the combined weighting of the social service components (education, health and social welfare) in the initial DOF formula was initially only 75 percent, and fell to 73% following revisions. The weightings for the other components of the formula are entirely arbitrary. Once again, the Financial and Fiscal Commission (1998: 15) noted that “*(w)ithout suggesting bad faith on behalf of the DOF, the use of arbitrary weightings can be open to manipulation*”. Expressed differently, if the weightings do not have an explicit and well-motivated basis, they can be changed on an *ad hoc* basis that can dramatically affect the ultimate global provincial budgets.

Apart from the weighting of the components of the formula, the most important difference between the FFC and DOF formulae is the component relating to provincial tax revenue (McIntyre *et al.* 1998). The approach proposed by the FFC was to attempt to estimate the revenue generating capacity for each province, and to compensate for these differences through allocations from the national level (that is, to ensure equitable shares of overall revenue when provincial taxation is implemented). The position adopted by the DOF is diametrically opposed to this in that it effectively gives money back to provinces in proportion to their contribution to the country’s economic outputs. The DOF uses what is in effect a proxy indicator for each province’s own tax revenue generating potential. The FFC criticised this as it “*has a countervailing effect on all the equity based shares which then runs contrary to devising a formula that redresses the inequities amongst provinces*” (Financial and Fiscal Commission 1998: 22). However, the DOF justified its use of the ‘economic output’ component in the formula by stating that “*(t)his component acknowledges the link between investment and infrastructure needs and related economic services, and the level of economic output in a province*” (Department of Finance 1998: E22). While the education, health, social welfare and basic components of the DOF’s formula are strongly equity promoting (in that more resources are being directed to poorer provinces relative to their population share), the economic output component is heavily biased in favour of the ‘richer’ provinces and thus, to some extent, diminishes the strength of the equity-promoting components. It is unclear to what extent the introduction of a ‘backlogs’ component to take account of the differing needs for infrastructural development across provinces will address this tension.

Although these formula design differences have impacted on resource allocation patterns, the factor that had the greatest influence on the relative budget shares proposed for each province by the two formulae was the use of different population data sources. The FFC used estimates produced by the Demographic Information Bureau (DIB) as the most recent census results were not available when it developed its formula. Provincial budgets for the 1997/98 financial year were based on the proportional distribution recommended by the FFC (that is, the 1997/98 allocations were ultimately based on the DIB population estimates). The DOF used the preliminary 1996 census data in calculating the provincial unconditional block grants for the 1998/99 financial year and the final census data for determining the 1999/2000 financial year block grants. Table 5.1 indicates that there are fairly substantial differences between the three data sets, particularly for four provinces, namely, the Eastern Cape (census versus DIB), Gauteng and Northern Province (preliminary census versus final census) and the Western Cape (considerable variation between all three data sets). As population is the primary component of all resource allocation formulae, inaccurate population distribution estimates will significantly and adversely influence resource allocation patterns. As a result of using three different population databases when determining inter-provincial budget allocations between 1997/98 and 1999/2000, some provinces were faced with considerable fluctuations in their block grants over this period.

Table 5.1: Comparison of different population data sets			
PROVINCE	PERCENTAGE SHARE OF THE POPULATION		
	Census 1996 (Final)	Census 1996 (Preliminary)	DIB 1995
Eastern Cape	15.5	15.5	16.3
Free State	6.5	6.5	6.7
Gauteng	18.1	18.9	18.3
KwaZulu-Natal	20.7	20.3	20.7
Mpumalanga	6.9	7.0	6.6
North West	8.3	8.0	8.5
Northern Cape	2.1	2.0	1.8
Northern Province	12.1	10.9	12.4
Western Cape	9.7	10.9	8.7

The use of inaccurate population data could not have been avoided, as the DIB and preliminary census estimates were arguably the most appropriate data available when the FFC and DOF formulae were respectively developed. However, given that it was universally acknowledged that the available population data were inaccurate, it is debatable whether the five-year redistribution period (used in both the FFC and DOF formulae) was appropriate. This five-year time frame resulted in budget shifts that are relatively large by international standards (for example, the Western Cape faced real global budget decreases of 14 percent between 1997/98 and 1998/99, and of 10 percent between 1998/99 and 1999/2000). It could be argued that it would have been more appropriate to initiate the redistribution process at a slower pace until the 1996 census data became available, to avoid potentially creating unnecessary budget fluctuations.

These design problems of the needs-based component of the DOF formula were exacerbated by the failure by 1999 to apply health sector norms and standards within the resource allocation process. In addition, the manner in which the conditional grants for health-related activities were calculated suffered from severe limitations; much in the same way as did the NITER component of the Health Function Committee formula. There were no improved data or methodologies to estimate the true financial value of training and highly specialised services offered on the nation's behalf by a limited number of provinces, nor were guidelines developed on appropriate spending levels for these activities within increasing budget constraints and changing priorities for service delivery. Likewise, there was continuing confusion as to whether these conditional grants were intended to fund highly specialised care for patients within the provinces receiving them, or for those outside the provincial boundaries as well (the funding of cross-boundary flows, for all levels of care, is generally a contentious issue). As the existing allocations for these services are substantial, there is a danger that spending on these activities could be protected without consideration of their relative priority and efficiency. Within this context of lack of guidelines and even elementary information, the re-distributive grant, which aims to develop some tertiary service capability in poorer provinces, could aggravate the problem of high levels of expenditure on lower priority services if used inappropriately.

An array of other problems also beset the conceptual thinking behind the 'horizontal division' formula, as they did the Health Function Committee formula (interview data; Doherty and van den Heever 1997). These included:

1. *How to address the differential backlog in infrastructure in different provinces.* Both the Clinic Upgrading Building Programme and later conditional grants for the rehabilitation of hospitals attempted to target capital funding towards under-served areas. However, these mechanisms were not clearly linked to the formula itself. Hence, the matching of additional capital funds with additional recurrent funding is not explicit, potentially

leading to facility development in the absence of capacity to run services at these facilities (or vice versa). This point is particularly stark in the case of the re-distributive grant. In addition, information on present capital development activities and expenditure levels is very incomplete. The wider problem of infrastructure backlog in some provinces – such as lack of electricity and water supplies, and the poor quality of roads – did, however, come to be addressed by changes in the DOF formula.

2. *How to take account of the availability of additional health care resources (such as local government health services, military hospitals, and employer-based services) in the formula.* These resources tend to be located in relatively advantaged provinces and effectively relieve some of the service burden on these provincial budgets. Although the DOF formula reflected the Function Committee formula in using population estimates for the health care weighting that excluded the insured population, there is some concern that this still does not adequately reflect the differential availability of private health care resources, and associated level of demand for public care, between provinces.
3. *How to bring about resource re-allocation within provinces.* The real benefits of resource shifts to poorer provinces will only be felt if they accrue to disadvantaged district management authorities within these provinces. However, as noted in **Chapter 4**, clear strategies to promote these shifts through an objective re-allocation mechanism (and other complementary policies) had not been developed or implemented on a large scale by 1999.

5.2.6 The inadequate support of parallel, institutional reforms

The extent of budgetary shifts between provinces and towards PHC services was, anyway, constrained by the enormous difficulties experienced in translating budgetary shifts into real shifts in human and physical resources. In particular, it is likely that in all provinces legal and practical problems with shifting personnel between settings meant that the planned shifts in budgets could not be translated easily into changed expenditure patterns (de Bruyn *et al.* 1998; Doherty and van den Heever 1997; McIntyre *et al.* 1998; interview data). Even though “*there was a money solution ... there was no real solution*” (government official, interview data) to the inherited problems of inequitable and inefficient resource allocations.

Two aspects of civil service reforms (or lack of them) were responsible for severely constraining the ability to re-allocate human resources: firstly, the negotiation of civil servants’ salaries in a ‘central bargaining chamber’; and, secondly, the mechanism for reducing the size of the civil service. The majority of provincial level spending is devoted to education and health services. Ninety percent of education spending and over two-thirds of health spending is in turn attributable to personnel costs (de Bruyn *et al.* 1998). The fact that civil servant’s salaries were determined at a national level severely constrained certain provinces’ ability to remain within the unconditional block grants awarded to them in line with the DOF resource allocation formula (see also **Chapter 9**). For example, provinces such as the Western Cape, which were faced with massive global budget cuts on an annual basis, yet were required to comply with centrally negotiated salary increases for civil servants, were hard pressed to meet budgetary targets. This problem became particularly stark in 1998 when a centrally bargained three-year agreement increased health personnel salaries substantially, especially through the vehicles of overtime payments and automatic promotions (interview data). Continual overspending by certain provinces may have adversely impacted on meeting the equitable resource allocation targets.

The constraints facing provinces in meeting their global budget targets and in redistributing personnel were also related to the second aspect of civil service reform. In 1996, the government imposed a moratorium on employer initiated retrenchments. Instead, the preferred tool for reducing the size of the civil service was the voluntary severance package (VSP). The relevant government department could not refuse a VSP to any applicant - they

could only postpone the effective date for the termination of services of key personnel to allow for suitable succession. Once someone accepted a VSP, they could not be re-appointed in the civil service. Many of the most highly skilled personnel, who could easily find employment in the private sector, applied for the VSP (de Bruyn *et al.* 1998). As this tool was not employer directed, in many cases the 'wrong' staff (either in terms of skill or relative degree of competence) left the civil service (see also **Chapters 3 and 9**). In addition, instead of redistributing skilled public sector staff from relatively well-resourced to currently under-resourced geographic areas and facilities, these staff either took early retirement, moved into the private sector or emigrated (McIntyre 1997b). Thus, the absence of adequate retrenchment and particularly relocation mechanisms had a significantly adverse impact on resource allocation initiatives. Expressed differently, more over-resourced provinces were limited to awarding a large number of VSPs to staff who then left the public service, instead of being able to negotiate the re-location, with incentives, of some excess staff to under-served areas.

5.3 Assessment of free care policies

5.3.1 Improving access

The Free Care policies were implemented to improve financial access to health care (Box 6, Figure 5.1). A formal evaluation of Free Care 1 found that it was successful in this regard, especially, according to a national household survey quoted by the evaluation, for traditionally marginalised groups (McCoy 1996). The reported utilisation increases at public facilities were usually between 20 and 60 percent. Part of this increase in overall utilisation was accounted for by an increase in the attendance of antenatal clinics (including first visits), a decline in the proportion of unbooked deliveries and an increase in family planning service attendance. The number and proportion of referred cases at clinic level also increased, suggesting that improved access to higher level facilities for those requiring referral was also achieved. This was partly borne out by the fact that paediatric admissions increased in all the hospitals studied by the evaluation. While there are no comprehensive data linking increased utilisation to reductions in mortality and morbidity, the Department of Health (1996a: 39) reports a survey of health providers as finding that "*three quarters of the public health sector workers believe that the policy was successful in preventing serious illness or death amongst women and children under 6 years of age*".

However, it is unclear whether the increases in utilisation prompted by Free Care 1 were sustained across the country. A separate study of utilisation patterns in a large network of health centres in Soweto, Johannesburg, showed early increases in antenatal attendance following the announcement of the policy, but a subsequent decline to levels lower than before the policy after 18 months (Schneider *et al.* 1997).

Although data on the impact of the second phase of free health care are scant, as it was never evaluated on a national scale, Free Care 2 is very likely to have again improved the financial accessibility of services. The Soweto study found large increases in utilisation, predominantly for curative services. There, total attendance was almost 49 percent higher in the ten months following the introduction of Free Care 2, compared to the equivalent ten-month period in the previous year (Schneider *et al.* 1997). Moreover, reviewing the evidence from a number of sources of the impact of both of the free health care policies on maternal care, Schneider and Gilson (1999: 98) conclude that:

"(t)he greatest impact of free care policies in South Africa appears to have been on the use of curative services. Given the relatively low levels of health service utilisation found in household surveys prior to free care policies, the increases in curative care visits do not necessarily correspond to inappropriate or frivolous use and may reflect a high level of previously unmet need".

Yet despite the utilisation gains resulting from the removal of fees, other barriers continued to affect access in some areas and population groups. Thus, following the first phase of free health care, a household survey indicated that 12 percent of Africans who did not seek care during the reporting period when they were ill cited high transport costs as the reason (Hirschowitz and Orkin 1995). As high transport costs are directly related to poor geographic access, this barrier seems to have constrained the general access gains from the first Free Care policy – largely, in turn, due to implementation problems (see **Chapter 9**). In some areas patients even remained untreated due both to drug shortages and the limits placed on how many patients could be seen by providers due to increased workloads (McCoy 1996). Geographic barriers had, however, begun to be addressed by the time of Free Care 2, for example through the general initiatives to improve PHC and the additional RDP funding, whilst there was at least a little more time for planning (see **Chapter 9**). Nonetheless, as geographic barriers are not addressed easily or quickly, they are likely to have continued to affect the access gains of Free Care 2 – particularly, for those who live in the more remote areas. Yet it is precisely these people, living in rural areas and former homelands, who have the highest morbidity and mortality rates and are in greatest need of health care (see **Chapter 3**). Thus, it may be that those with the greatest capacity to benefit from free health care derived the least benefit from these policies.

5.3.3 Impact on resource use and availability

Following the implementation of the Free Care policies some concern was expressed about their potential to have reduced, rather than enhanced, allocative and technical efficiency within the health system – which, in turn, would have had a broad impact on resource availability for primary care (i.e. impacting on Box 4, Figure 5.1). For example, although it is not clear whether this perception was accurate, a major concern of providers in relation to Free Care 1 was that patients were abusing and overusing health services (85 percent of respondents) (McCoy 1996). More importantly, providers also felt that there was inappropriate use of secondary and tertiary facilities (that is, patients were attending these facilities for health problems that could have been addressed at the primary level).

This problem partly arose from the design of the policy in that care at all levels of the health service was made free for the target groups, irrespective of whether they followed the referral route or not. This was contrary to recommendations fed into the ANC's National Health Plan in the early 1990s which had specified that health care would be free for the target groups '*at the point of first contact*' and at other levels of care '*on referral*' (analyst, interview data). This proposal was in line with the international literature on user fees which argues that a differential fee structure, with the lowest or no fees at the primary care level, and possibly 'bypass fees' for those who do not follow the correct referral route, will promote appropriate use of services and allocative efficiency (see for example Akin *et al.* 1987; Birdsall 1985). Yet despite the concerns of both the ANC Financing and Maternal and Child Health Commission, the final ANC National Health Plan (and subsequently the RDP document) did not include this level of design detail (see Box 5.3). As the Presidential announcement of the first Free Care policy in May 1994 was, in turn, based on the abbreviated design recommendations contained in the RDP, it also did not include provision for by-pass fees.

Box 5.3: A comparison of policy statements on user fees by the ANC Health Plan and the RDP

The ANC's National Health Plan

'Free health care will be provided in the public sector for children under six, pregnant and nursing mothers, the elderly, the disabled, and certain categories of the chronically ill. Preventive and promotive activities, school health services, antenatal and delivery services, contraceptive services, nutrition support and curative care for public health problems will also be free, in the public sector. Because of the burden associated with paying for health services at the time of illness, in the long term we are committed to the provision of free health care at the point of service for all citizens of South Africa. Individuals covered by some form of health insurance will not be eligible to receive free health care. User fees for insured patients using public sector facilities will be increased to ensure full cost recovery.'

The RDP

'Health care for all children under 6 years of age, and for all homeless children, must immediately be provided free at government clinics and health centres. ... There must be a programme to improve maternal and child health through access to quality antenatal, delivery and postnatal services for all women. ... These services must be free at government facilities by the third year of the RDP. ... Within a period of 5 years, a whole range of services must be available free to the aged, the disabled and the unemployed and to students who cannot afford health care'

Sources: African National Congress 1994a: 75; 1994b: 46

In addition, given that patients perceive hospital-based and doctor-provided care as being of a higher quality (McCoy 1996), a preference for direct use of higher level facilities would not be surprising. In areas where there were no or inadequate primary care facilities, the direct use of hospitals was unavoidable in any case. However, there is some doubt as to whether inappropriate utilisation was truly of the level perceived by health workers. The evaluation of Free Health Care 1 found no evidence to support the supposition that the policy caused a relatively greater increase in hospital utilisation as opposed to clinic utilisation (that is, increases were generally across the board). Studies from two tertiary hospitals suggested that, while the number and proportion of visits that could have been handled at lower levels had indeed increased, *"where a well-functioning system of primary care facilities existed, the impact on the tertiary hospital was less significant"* (McCoy 1996: 13).

In contrast, the second phase of the free health care policy was clearly potentially beneficial from an allocative efficiency perspective. As the financial accessibility of only PHC services was improved, there was a clear incentive for patients to use these services as the first point of contact. In addition, some provinces implemented a bypass fee at hospitals as a disincentive to bypassing the referral route. However, the lack of access to doctors at many health care facilities and the preference of many patients for doctor-provided services would have reduced the effect of this financial incentive. Some provinces, such as the Free State, felt that a bypass fee could only be imposed if there were good geographic access to PHC services and if these services were of high quality, relying only on radio advertising to encourage communities to use the appropriate level of care (see **Chapter 9**).

The Free Care policies, finally, also had some impact on revenue generation within the health system, and so also, potentially, on its ability to expand and sustain lower level services (via Box 4, Figure 5.1). McCoy (1996) reports that revenue from user fees dropped by 30 percent in most of the PHC facilities and provinces in the twelve months following the implementation of the Free Care 1 policy. However, this amount corresponded to only 1.5 percent of the total health budget and, in any case, had never been retained by health departments (being returned to provincial treasuries). Although there are no data on revenue lost due to Free Care 2, earlier analysis indicated that revenue collected from PHC services represented less than 3 percent of the total health budget (McIntyre *et al.* 1995). Data from one province - the former Cape Provincial Administration - show that the revenue from non-hospital PHC services was even lower, at less than 1 percent of the province's health budget

(McIntyre 1994b). Given that the costs of collecting fees were removed through both policies⁵, the overall impact of either Free Care policy on revenue availability was probably very limited.

5.3.4 Impact on service quality

Perhaps the most significant, unintended and negative effects of the Free Care policies were on the (perceived) quality of service provision. Despite popular support for the introduction of Free Care 1, concerns soon emerged in the press that the quality of care at public sector facilities had suffered, particularly in terms of overcrowding, lengthy waiting periods, lack of doctors, shortages of medicines and negative staff attitudes and behaviour towards patients. A national household survey found that 17 percent of respondents felt that the quality of care had in fact deteriorated after the introduction of Free Care 1 (Hirschowitz and Orkin 1995). A later survey found considerably higher levels of dissatisfaction with quality, with 62 percent of respondents dissatisfied with the care received (McCoy 1996). The advent of Free Care 2 continued the debate in the press around the viability of the policy but there was limited information on user acceptability. The only available study, based on exit interviews at four clinics, found that although users generally welcomed the policy they were concerned about the accessibility and quality of PHC services (Magongo and Cabral 1996).

Deteriorating quality can be understood partly as a result of inadequate resources in the face of heightened demand. Inadequate resources can in turn worsen provider morale. McCoy (1996: 33) found that the increased workloads from Free Care 1 “*accentuated other problems and grievances such as low salaries, poor working conditions, tensions between colleagues, staff shortages, lack of physical space, and tension between health workers and patients*”. But poor provider morale, and the consequent impact it has on service quality, can also be directly attributed to the way in which both Free Care policies were implemented (see **Chapter 9**).

Some researchers have also expressed a concern that free PHC has led to a crowding out of preventive services by curative services. Wilkinson *et al.* (1998) report that in the Hlabisa District in KwaZulu-Natal, attendance for curative care at a network of mobile service points between 1994 and 1998 increased by 93% while attendance for antenatal care decreased by 20%. Data from other parts of the country are not readily available although a health official in one province suggested that teenage pregnancy rates climbed, and immunisation and TB cure rates dropped in some areas following the introduction of free PHC (interview data). Such data cannot, however, be taken to represent a long-term trend and initial impacts on utilisation patterns may not be sustained.

5.4 Summary and conclusions

The main achievements and limitations of financing reforms over the 1994-99 period are summarised in Table 5.2 according to their contributions to health equity and health system sustainability. Overall, the broad success of these reforms is in making strong moves towards re-orienting service provision towards the needs of the population at large. This success is particularly impressive given the relatively short space of time (5 years) in which it has occurred. It has been achieved mainly through the provision of free services, but was supported in the early years by resource allocation policies that were needs based. Thus, the explicit objectives of the reforms (see **Chapter 2**) were attained to some degree. In addition, the Free Care policies generated substantial public support for the new government as it improved financial access to health care for needy groups (McCoy 1996). In the press, both policies - but especially Free Care 2 - have been held up consistently as Minister Zuma's hallmark achievement. The public recognition of these reforms helped to endorse the

⁵ In the legislation, medical scheme members are still required to pay for PHC services at public facilities. However, the general perception is that public PHC is free to everyone and anecdotal evidence suggests that fee collection has been done away with at many facilities.

Department of Health's broader reform agenda, giving credence to its ongoing activities, as well as bolstering the popularity of its leaders when under fire from other quarters (see **Chapter 7**).

Yet these considerable achievements went hand in hand with increased instability in certain aspects of the health system. Uncertainty in planning, poor provider morale, declining quality of care and some public disaffection with parts of the public health system are all by-products of reform which make the task of further reducing inequities that much harder. Even with respect to reductions in inequity, favourable early trends in resource re-allocation are being jeopardised by the current process of global budgeting.

Table 5.2: The main achievements and limitations of financing reforms	
<i>Reductions in inequity</i>	<i>Persistent inequities</i>
<ul style="list-style-type: none"> • The resource allocation formulae contributed to some re-distribution of health budgets between provinces. • Financial barriers to access, especially to PHC, were reduced through the two free health care policies. • Budget re-prioritisation towards PHC improved geographical access to these services. 	<ul style="list-style-type: none"> • Global budgeting has reduced or reversed inter-provincial shifts in health spending. • The free health care policies did not address the broader (e.g. transport) costs of accessing health care. • Re-prioritisation of PHC, as supported by the resource allocation formulae, may not have been effective in realising improved PHC services in the worst-off areas of the country.
<i>Improved sustainability of aspects of the health system</i>	<i>Persistent problems with sustainability</i>
<ul style="list-style-type: none"> • The free health care policies garnered popular support for the broad reform agenda of the government. • Re-prioritisation of budgets (supported by the resource allocation formulae) may have led to greater spending on PHC. 	<ul style="list-style-type: none"> • The reforms led to some dissatisfaction with public health services, especially hospitals. • Spending on health care has become dependent on political jockeying at the provincial level. • Planning has been destabilised to some degree, but more important problems are worsening provider morale and declining quality of care.

This chapter has also sought to go some way in explaining unintended impacts by scrutinising the design of the reforms. Table 5.3 summarises the most salient design features of the individual reforms and their potential influence over reform impact. Interestingly, although the removal of fees goes against the international trends, the South African experience nonetheless confirms two aspects of wider experience (Gilson 1997a). In designing fee systems it is important to consider, first, the incentives fee levels create for utilisation of different levels of care, particularly in relation to their impact on referral patterns. Second, fee exemption mechanisms (including fee removal at specified health facilities) need to be structured carefully and, in particular, complemented with other policies in support of service development, if access by the poorest is to be promoted (as highlighted in Figure 5.1). This analysis, however, emphasises that it is also important to take account of parallel, institutional reforms, particularly with respect to decentralisation and modernisation of the civil service, when designing financing reform. **Chapter 10** presents a range of more specific conclusions and recommendations on policy design.

Two final conclusions can be drawn from this analysis. First, a priority for future policy development in South Africa is to develop mechanisms to promote equity in health care spending within the environment of fiscal federalism. Second, it is important to establish methodologies and processes for evaluating the impact of reforms in the future. Judging the overall impact of the reforms of 1994-99 is difficult due to the paucity of available information and formal evaluations. The problems include the difficulty of assessing the extent to which real shifts in expenditure (as opposed to budgets) have occurred on the ground and of understanding the impacts on the poorest of the poor whose voices are rarely reported.

The available, scanty data on the impacts - both positive and negative - of financing policy must, therefore, be interpreted with caution, lest they prove to be transient in nature.

Table 5.3: Overview of key design issues and effect on impact	
DESIGN ISSUE	INFLUENCE ON REFORM IMPACT
<i>Design problems in individual reforms</i>	
Free Care 1 did not specify that services free only at primary care level, or at other levels only on referral.	❖ Many patients possibly went directly to higher level facilities for care that could have been provided at primary care level that had an adverse allocative efficiency impact.
The Health Function Committee formula had the following problems: <ul style="list-style-type: none"> ❖ NITER was an arbitrary 25% allocation for all provinces with academic hospitals; ❖ there were inadequate estimates of relative need, including inaccurate population data; and ❖ there was an excessively rapid pace of redistribution. 	<ul style="list-style-type: none"> ❖ There were massive, sometimes unmanageable, budget cuts for some provinces, especially those with the majority of academic hospitals. ❖ There was an inability to absorb all additional budget resources in provinces receiving large increases. ❖ Some redistribution patterns may need to be reversed as future allocations are refined and more accurate data become available.
The DOF formula for global provincial budgeting has the following problems: <ul style="list-style-type: none"> ❖ there is an historical expenditure-based weighting for social service formula components; ❖ there is arbitrary weighting for other formula components; and ❖ the economic output weighting is contrary to the equity goals of the overall resource allocation formula. 	<ul style="list-style-type: none"> ❖ Social service components are not weighted to reflect policy priorities. ❖ The arbitrary weightings are open to manipulation that could substantially affect the extent to which the formula is equity promoting. ❖ The equity impact is partially offset by the economic output component.
In global budgeting formulae in general: <ul style="list-style-type: none"> ❖ population data were inaccurate in earlier years and fluctuated over time; ❖ there was a lack of consideration of equity within cross-provincial review processes; ❖ there was a lack of mechanisms (such as norms and standards) to influence health resource allocation decisions under fiscal federalism; ❖ there was a lack of consideration of how to account for extra-budgetary resources under fiscal federalism; ❖ there was a lack of clarity on the linkages between reallocation of recurrent and capital resources. 	<ul style="list-style-type: none"> ❖ Uncertainty about budget allocations constrained rational planning processes and limited resource redistribution. ❖ The pace of inter-provincial health care resource allocation was slowed, and in some cases reversed. ❖ The inequities between currently over-resourced provinces (which are most likely to be able to generate extra-budgetary resources) and least well resourced provinces were potentially exacerbated.
<i>Lack of recognition of inter-relationship between financing and organisational reforms</i>	
Complementary policies to support PHC were not wholly successful in removing non-financial barriers to access for all population groups.	❖ Non-financial barriers to access continued to limit access to care for the poorest.
Political decentralisation and the introduction of fiscal federalism had an unplanned effect on inter-provincial health care resource allocation	❖ The pace of inter-provincial health care resource allocation was slowed, and in some cases previous health resource redistribution gains were reversed.
There was insufficient consideration of the need for civil service reform to support resource allocation goals.	<ul style="list-style-type: none"> ❖ Centrally negotiated salary structures made it difficult for relatively over-resourced provinces to meet budget reduction targets. ❖ Lack of relocation mechanism limited the extent to which redistribution of financial resources could be translated into a redistribution of staff and, hence, services.

CHAPTER SIX ADDRESSING CRITICAL HEALTH CARE FINANCING REFORM CHALLENGES: DOES SHI HAVE A ROLE?	83
6.1 Key continuing equity and sustainability challenges	83
6.2 The potential role of social health insurance in addressing these challenges	87
6.3 Issues to be resolved if SHI is to be taken forward	93
6.4 Summary and Conclusions	97

CHAPTER SIX

ADDRESSING CRITICAL HEALTH CARE FINANCING REFORM CHALLENGES: DOES SHI HAVE A ROLE?

Following the analysis of Chapter 5, this chapter considers whether a SHI scheme can play a role in addressing some of the most important equity and sustainability challenges for the health system existing in 1999. From the experience of the 1994-99 period it also identifies key design issues that need to be addressed to allow SHI to be taken forward. This technical analysis links to the analysis of Chapter 8, that considers the factors influencing the process of SHI policy development over the 1994-99 period. Further conclusions and recommendations derived from this analysis are presented in Chapter 10.

6.1 Key continuing equity and sustainability challenges

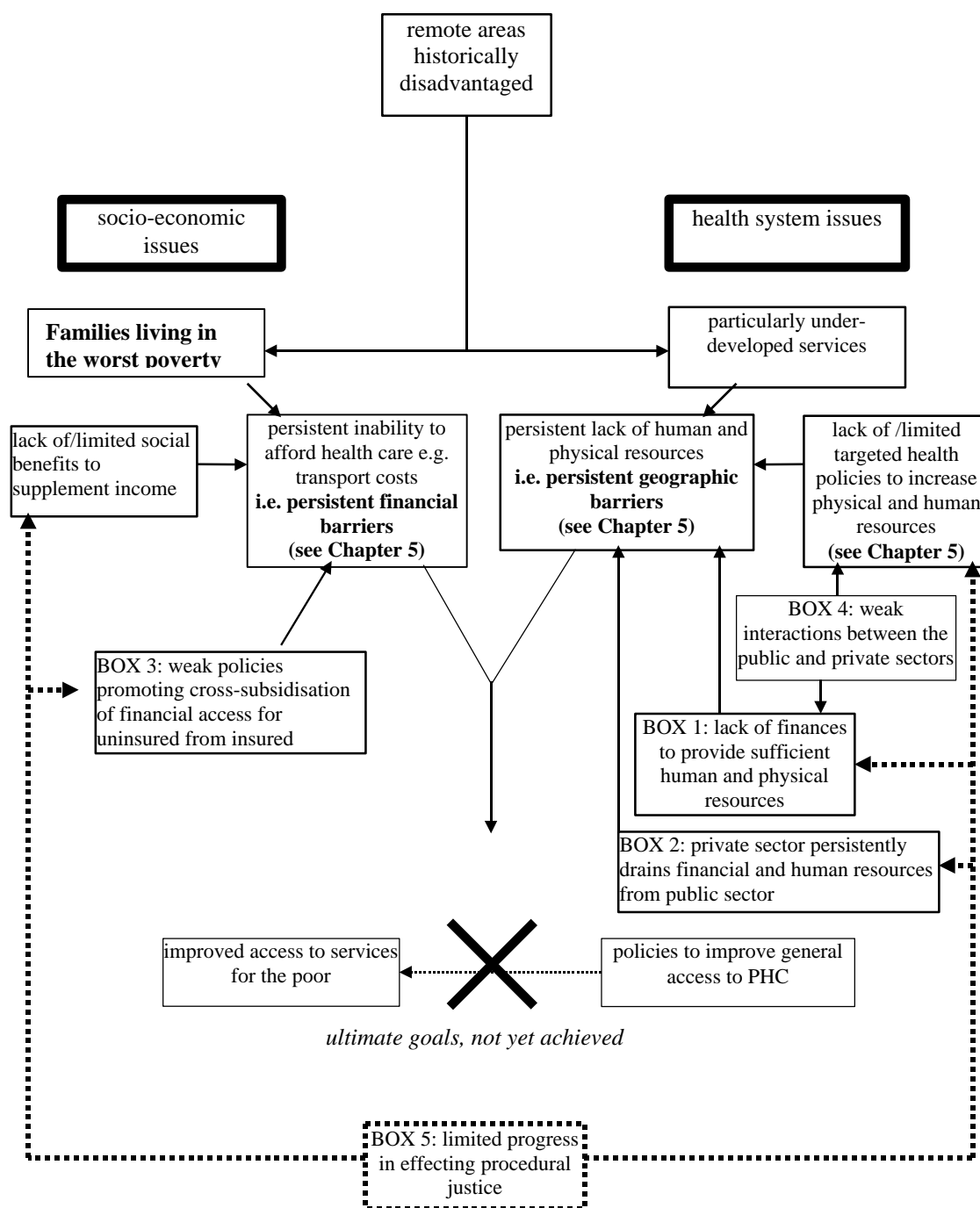
Chapter 5 indicated that substantial progress was made in addressing equity and sustainability problems in the South African health sector over the 1994-99 period. However, Figure 6.1 summarises some of the key continuing equity and sustainability challenges for the health system, specifically highlighting how they affect the health system situation of the poorest South Africans. These groups not only face health system weaknesses but also socio-economic barriers to accessing care.

The previous chapter highlighted those continuing challenges that require refinement of existing policies plus the implementation of additional supporting measures for these policies, particularly creating mechanisms to promote equitable resource allocation within a fiscal decentralisation context. This chapter focuses instead on challenges that have not yet received sufficient policy attention or which require considerable additional policy development – identified in Boxes 1-3 of Figure 6.1. They are all aspects of the most critical continuing health care financing challenge facing the South African health system - that of extending ‘the degree of cross-subsidy within the overall health system’ (McIntyre and Gilson, forthcoming). This issue is integrally linked to changing the existing public-private mix in terms of resource availability relative to the population served by each sector. Addressing the issue is of importance to health system sustainability from the perspective of securing a relatively greater share of health care resources for the public sector, which serves the majority of South Africans. It also has important equity implications, as improving access to health care for previously marginalised groups is critically dependent on changing existing health sector cross-subsidies.

6.1.1 Threatened financial sustainability

As discussed in **Chapter 5**, tax-funded per capita public sector health care expenditure is stagnating. This means that changes in the provision of health care have to be effected through the re-distribution of existing budgets, which makes reform all the harder. The lack of large new sources of funds has limited the possibilities for transformation, constraining PHC development as well as threatening the integrity of hospital services (Box 1, Figure 6.1). The continued constraints on public sector resources also limit the possibility of redistributing resources between geographic areas, and particularly of improving health service access for historically disadvantaged communities (see also **Chapter 7**).

Figure 6.1: The routes through which the poorest of the poor may still be excluded from benefits (1999)



The situation worsens daily as existing user fee revenue collection at hospitals declines, due to the lack of incentives for collection (e.g. revenue retention), poor structure and pricing of the user fee schedule, poor collection systems and a leakage of patients to the private sector (Monitor Company *et al.* 1996; interview data). Technical inefficiencies, especially in public hospitals, have by and large not yet been addressed, mainly because of slow progress in transforming hospital management.

While technical efficiency gains could potentially release resources for improved health service access for those in greatest need and contribute to enhanced financial sustainability, additional resources are urgently required in the public health sector if substantive resource redistribution (both between geographic areas and levels of care) is to be achieved. Given that overall health expenditure levels in South Africa are already relatively high by international standards (McIntyre *et al.* 1995), addressing the distribution of resources between the public and private sectors relative to the populations they serve, is critical.

6.1.2 Continuing public to private cross-subsidies

The private sector benefits from public sector subsidies in a number of different ways. These include tax deductions on medical scheme contributions and the heavily subsidised training of health workers, the majority of whom leave to work in the private sector shortly after graduation (McIntyre *et al.* 1995; Box 2, Figure 6.1). The Hospital Strategy Project documented a range of ways in which the private sector captures state subsidies intended for the care of indigent patients in public hospitals (Monitor Company *et al.* 1996):

1. Expensive cases are 'dumped' on the public system by insurers once their insurance benefits have been exhausted in private hospitals (Box 2, Figure 6.1);
2. Insured patients frequently claim to be uninsured and thus do not pay for their care at public hospitals (Box 3, Figure 6.1);
3. The fees charged by public hospitals for the care of private patients often fail to recover the full costs of that care, let alone generate a surplus for cross-subsidisation of public patients (Box 3, Figure 6.1);
4. Poor billing systems often fail to charge and recover fees from insured patients (Box 3, Figure 6.1).

In addition, the rapid expansion of the private hospital sector in recent years has undermined public provision by draining large numbers of highly skilled staff out of public hospitals, and by drawing increasing numbers of paying patients out of the public hospital system (Monitor Company *et al.* 1996).

It is of considerable concern that limited government resources, which should be directed to health services for those with the least ability to pay, continue to be used to subsidise private sector financing intermediaries and private providers which largely serve the most affluent South Africans.

6.1.3 Limited progress in devising constructive public-private partnerships

Underlying the continuing public to private cross-subsidies is, in part, the limited progress achieved over the 1994-99 period in devising constructive public-private partnerships (Box 4, Figure 6.1). In 1996, the Hospital Strategy Project commented that "*(t)he current interaction between the private and public sectors in the hospital system does not generate any of the potential positive effects of such interactions, but instead has a strongly negative effect on the public sector*" (Monitor Company *et al.* 1996). Consequently, the Project identified the creation

of an effective public-private interface that contributes positively to the public hospital system as one of its eight key strategies for sustaining the public hospital sector and, by implication, the public sector as a whole. Mechanisms for improving this relationship are summarised in Box 6. as a scheme against which to measure progress by 1999.

Box 6.1: Promoting the sustainability of public hospitals through an enhanced public-private interface

Controlled expansion of private hospital beds

There should be clear criteria for licensing private hospitals and a strong licensing authority should be set up. A license should be refused if a private hospital could impact negatively on the public system (e.g. by attracting away public personnel). Instead, efforts should be made to accommodate the demand for private beds within existing public hospitals.

Competition with private hospitals

The public hospital system should compete with private hospitals to attract paying patients (and with them, private practitioners) back into the system. Strategies could include improved hotel facilities.

Prevention of 'dumping'

Regulations should be enacted to prevent 'dumping' of private patients on public hospitals when their benefits are exhausted.

Creative public private partnerships

Such partnerships should be explored in all aspects of hospital service e.g. the use of private sector expertise in various aspects of hospital management and service delivery, the use of spare capacity in private hospitals for public patients, and creative partnerships with private practitioners.

Source: Monitor Company *et al.* 1996

An important step in addressing these problems is the 1998 Medical Schemes Act, which prohibits 'dumping'. But it will yield results only slowly and its impact will require monitoring. Moreover, by 1999, little progress had been made in relation to other interactions. The official moratorium on opening new private hospitals was neither watertight nor linked to a systematic process of controlling the development of private sector facilities countrywide. Little action had been taken to increase the attractiveness of public sector care, in order to draw private patients back into public facilities. Admittedly, this is a difficult task, involving as it does an array of complex changes, including improving the quality of care, hotel facilities, billing mechanisms and revenue retention procedures, not to mention confronting the issue of whether separate amenities - such as private wards - should be made available for 'private patients'. Similarly, no action was taken on the proposal by the 1995 Committee of Inquiry that districts purchase primary care services from accredited private providers as a mechanism for strengthening public care through accessing physical resources resident in the private sector (McIntyre and Gilson, forthcoming).

These piece-meal interactions with the private sector over the 1994-99 period suggest that there was no clear national strategy for managing the threats the private sector poses to public sector activities. Or, more positively, for taking advantage of the array of resources and skills the private sector has to contribute to public sector provision.

6.1.4 Limited progress in improving procedural justice

Chapters 7-8 identify the weaknesses in processes involving parliamentary institutions as well as members of the public in decision-making around health care financing. In general, health reforms appear to have fallen short, thus far, of establishing mechanisms by which citizens become actively engaged in determining how public action can meet the needs of the poorest. As Figure 6.1 (Box 5) suggests, this failure to distinguish the voices of the poorest of the poor may have contributed to the failure of a range of other equity-oriented policies to extend benefits to this group. The relatively closed nature of health policy formulation may also have contributed to the lack of progress in addressing public-private mix issues. The concerns of the more affluent sections of society will tend to dominate decision-making in the absence of mechanisms for broader societal participation (McIntyre and Gilson 1999; McIntyre and Gilson forthcoming).

6.2 The potential role of social health insurance in addressing these challenges

Social Health Insurance (SHI) was identified even before 1994 as an important potential mechanism for improving cross-subsidies in the overall health system in South Africa through addressing the relative public-private mix of resource availability and population coverage (see for example de Beer and Broomberg 1990c; McIntyre 1997a; South Africa 1995). The various proposals for a SHI (see Figures 4.1 and 4.3, **Chapter 4**) were partly aimed at promoting cross-subsidies from the rich to the poor, the young to the old, and the healthy to the sick – reversing the existing perverse cross-subsidy from the worst-off to the best-off through public subsidisation of the private health sector.

This cross-subsidisation would be achieved in two ways. Firstly, SHI was seen as a means of addressing the distortions of the private sector (partly tackling Box 2, Figure 6.1), particularly:

- ‘dumping’ on the public system due to limited benefits coverage in private medical schemes;
- decreasing affordability of medical scheme coverage as premiums escalate due, amongst other things, to risk-rating and low cost-effectiveness resulting from the perverse incentives inherent in a ‘third-party payer’, fee-for-service system; and
- declining access to medical scheme cover due to ‘exclusions’ (i.e. the creation of population groups who would be uninsurable).

Secondly, it was argued that SHI would increase health insurance coverage in the population and would increase resource availability in the public sector for those truly dependent on these services (tackling Box 1 and, perhaps, Box 3, Figure 6.1). Participation in the SHI was to be mandatory for those presently uninsured who could afford cover if it were reasonably priced. SHI members could either use private sector services, thus releasing limited tax-funded public sector resources for the indigent, or use public sector services but cover the full cost of these services.

As SHI, thus, has considerable potential for addressing some of the important health care financing challenges in South Africa, it is considered in some detail in the rest of this chapter. The major focus of the following analysis will be on the 1997 SHI policy proposals, the last set of proposals developed in the 1994-99 period. However, aspects of earlier S/NHI proposals will also be considered to provide a more comprehensive review of the ways in which SHI might contribute in future to meeting health sustainability and equity objectives.

6.2.1 Potential contribution of SHI to health system sustainability

As outlined in **Chapter 4**, the 1995 Committee of Inquiry was established to develop a detailed plan for achieving universal access to primary care services, a key health policy goal. The Committee estimated that an additional R2.3 billion (expressed in 1995 terms) would be required in 1997/98 to finance the proposed expanded primary care services (South Africa 1995). By 1999, no concrete action had been taken to secure funding for this primary care gap. McIntyre (1997a), in a detailed review of existing and alternative financing sources, argued that within the constraints of the existing fiscal environment and Department of Finance taxation policy, a SHI combined with improved public hospital fee systems was the most feasible source of finance for improving primary care services. Box 6.2 provides some estimates of user fee revenue generating potential with increased insurance coverage through SHI.

Box 6.2: Estimated fee revenue under a SHI

McIntyre (1997a) used the following assumptions in estimating the potential fee revenue at public sector hospitals if a SHI were introduced in South Africa:

- All formal sector employees and their dependants would be covered (in line with the Committee of Inquiry proposals (South Africa 1995), but not the Department of Health's (1997) later recommendation that only employees above the income tax threshold be covered);
- The SHI would cover the full costs charged at public sector hospitals;
- The newly insured (i.e. those not currently members of medical schemes and who are likely to be low income earners) and members of low-income employee benefit schemes and 'exempted' schemes (which provide little or no hospital cover at present) were likely to continue to use public sector hospitals, given that the full costs would be covered;
- Members of comprehensive medical aid schemes and holders of catastrophic health insurance policies are likely to continue mainly using private hospital services (and if necessary take out 'top-up' insurance to cover the extra costs);
- The number of public sector inpatient days which would be attributable to SHI members was estimated using the average admission rate for non-medical aid members and the average length of stay; and
- The majority of current fee revenue is attributable to patients who would become SHI members, i.e. to those employed in the formal sector.

Using a comprehensive data-set of costs per inpatient day and current fee revenue in each public sector hospital in South Africa (using 1992/93 data), the *additional* revenue that could be generated from SHI members who use public sector hospitals was calculated under two different scenarios:

- If fees were set at average cost-recovery levels, i.e. [No of inpatient days which would be attributable to SHI members x average inpatient day cost for that level of care] - current fee revenue: Approximately R1.23 billion additional revenue would be generated (compared with R688 million current fee revenue).
- If fee levels were set at 50 percent of actual private hospital charges (a crude estimate of the RAMS Scale of Benefit ward charges plus itemised charges for some high cost items) Approximately R4.3 billion additional revenue would be generated.

The Department of Health (1997) estimated potential revenue generation levels of between R1.5 and R3 billion in 1997 terms, using the assumption that only those formal sector employees above the income tax threshold would belong to the SHI.

If the revenue generated through a combination of improved public hospital user fee systems and SHI is retained within the health sector, it could be used to reduce hospitals' reliance on budgetary funding (i.e. from general tax revenue) and budget resources could increasingly be reprioritised towards primary care services (McIntyre 1997a; Monitor Company *et al.* 1996). The link between a SHI for hospital services and hospital user fees on the one hand and improved

funding for primary care services on the other hand is a critical one, which was not adequately recognised in most formal health policy documents over the 1994-99 period.

Thus, a SHI could potentially contribute significantly to overall health system financial sustainability in South Africa by drawing additional revenue into the public sector which could be used to improve access to primary care services while ensuring adequate hospital referral services remain intact. However, the above estimates do not take account of additional costs that may be incurred in securing this revenue. In particular, public sector hospitals may need to offer improved inpatient 'hotel facilities' if they are to attract SHI members. In addition, not all civil servants are presently covered by medical schemes. Mandatory SHI for all formal sector employees could mean that additional general tax revenue would have to be devoted to SHI contributions for civil servants. This would depend on SHI contribution levels as well as whether the government continues current contribution levels for civil servants who are presently medical scheme members. Thus, improved health system sustainability under a SHI would require that the additional revenue generated at public sector facilities (or the resources 'released' if SHI members choose to use private sector services) exceeds the additional costs to government of the SHI and user fee revenue generation efforts.

Another critical financial sustainability issue related to SHI is that of the ability to control expenditure, not only expenditure on services (e.g. prevent excessive utilisation) but also on SHI administration. SHI tends to have relatively high administrative costs, which reduces net revenue generating potential. In addition, if SHI expenditure is not adequately controlled, contribution rates will have to be increased which could have adverse macro-economic impacts, by increasing the cost of labour and possibly unemployment, which will in turn jeopardise SHI sustainability. Administrative efficiency is dependent on the availability of skilled staff and appropriate information systems (Abel-Smith 1991). While some believe that current medical scheme administrators have the potential to administer a SHI, others vehemently disagree (various policy analysts, interview data). The development of adequate administrative capacity would be critical to SHI sustainability. Similarly, the assumption that through competition SHI would exert an influence over costs in the private sector needs investigation. Medical schemes have historically had great difficulty in introducing managed care practices into the industry.

A remaining financial sustainability concern is that extra-budgetary resources (such as retained user fee revenue) are often viewed as being an additional tax by the Department of Finance (see also **Chapters 7 and 8**). Thus, although considerable resources could be generated through user fees at public sector hospitals for SHI members, if this is entirely offset by reductions in allocations from general tax revenue, there is no improvement in financial sustainability for the public health sector. Further debate with the Department of Finance on this issue is clearly critical.

6.2.2 Potential equity impact of S/NHI in South Africa

All of the N/SHI proposals already developed within South Africa have the potential for some favourable impact on existing inequities. The earliest proposals (from 1988/89 and 1990 – see Figure 4.1 in **Chapter 4**) have the greatest potential impact (assuming that they are politically and financially sustainable), in that they envisage a wide coverage for NHI and explicitly exclude tiering of services for different income groups (de Beer and Broomberg 1990c). Even these proposals however, do not address inequities entirely as they allow for the continued purchase of private, non-NHI care by high-income groups. This is also a feature of the later proposals, where potentially more people are likely to take out 'top-up' cover. This may not only have represented a concession to powerful elites in order to lessen opposition to NHI but may also have reflected a

perception that the prime equity objective of S/NHI is to create universal access to *essential* services, rather than to all services (see also **Chapters 7 and 8**). Expressed differently, equity is promoted if the *minimum* services enjoyed by all have improved, regardless of whether there are disparities at the top end of the scale. How these essential services are defined (i.e. whether they represent all cost-effective interventions or, perhaps more likely, a more limited set of interventions determined by resource constraints) is, thus, important in determining the extent to which equitable health outcomes will be promoted by NHI. As more and more health care funds are spent outside the N/SHI system (especially if the opportunities to achieve risk-pooling are eroded), there may well be less to spend within it, placing increasing pressure on the basic package of services.

Even though NHI would entitle everyone to appropriate health care regardless of income or health condition, it would not, at least in the short term, do away with certain geographic and financial barriers or deal with disparities in the quality of care offered by different facilities (Figure 6.1, see also **Chapter 5**). Thus, the shortage of facilities with well-trained staff and adequate equipment in previously dis-advantaged communities – and the financial burdens associated with attending services in these areas, such as transport costs and excessive time spent seeking care – reduce the benefits afforded these communities by NHI. While these problems could be expected to lessen over time as the public service re-prioritises services to such areas, the worst-off may be the ones who benefit last from a NHI.

Although perceived by some to be more politically acceptable and feasible to implement in South Africa than an NHI, the various SHI proposals developed in the 1994-99 period (see Figure 4.3, **Chapter 4**) would have a less favourable impact on inequities than a NHI. Two of the key equity concerns with such systems are firstly the explicit differential service access for SHI members and non-members and secondly, the overall effect on health system cross-subsidies. In relation to differential service access, SHI members would probably need to be offered incentives to use public sector facilities such as improved ‘hotel services’ and a ‘fast queue’ for non-emergency outpatient services. Such differentiation may lead to differences in the clinical quality of care, for example, better-qualified personnel may be allocated to ‘private wards’ and more resources may be expended on patients in these wards. Although this differentiation in hotel facilities and other aspects of services was a controversial element of the SHI proposals (see **Chapter 8**), it could be seen as a trade-off to allow public health services to achieve other important objectives. For example, it may promote the use of public hospital services by a range of income groups which could provide considerable political support for securing adequate government funding of these facilities (i.e. public hospitals will not only be used by the poorest who have limited political ‘voice’) (Gilson 1998).

With respect to cross-subsidies, as highlighted previously, the key consideration is that of addressing the currently inequitable public-private sector resource and population coverage mix. This issue can probably best be illustrated by considering the 1997 SHI proposals (Department of Health 1997a) as there are concerns that this particular SHI design would have the least favourable equity consequences of all of the N/SHI options considered over the past decade. It is also important to consider the 1997 proposals in some detail, given that they are regarded as the foundation of any future SHI policy (interview data). The 1997 proposals are compared to the SHI formulation immediately preceding them (namely the Committee of Inquiry’s SHI recommendations) to highlight how different SHI designs may influence the extent of cross-subsidies within the health sector.

The Committee of Inquiry’s SHI recommendations indicated that SHI members could be covered either through an existing medical scheme or “*a new state sponsored hospital plan, the*

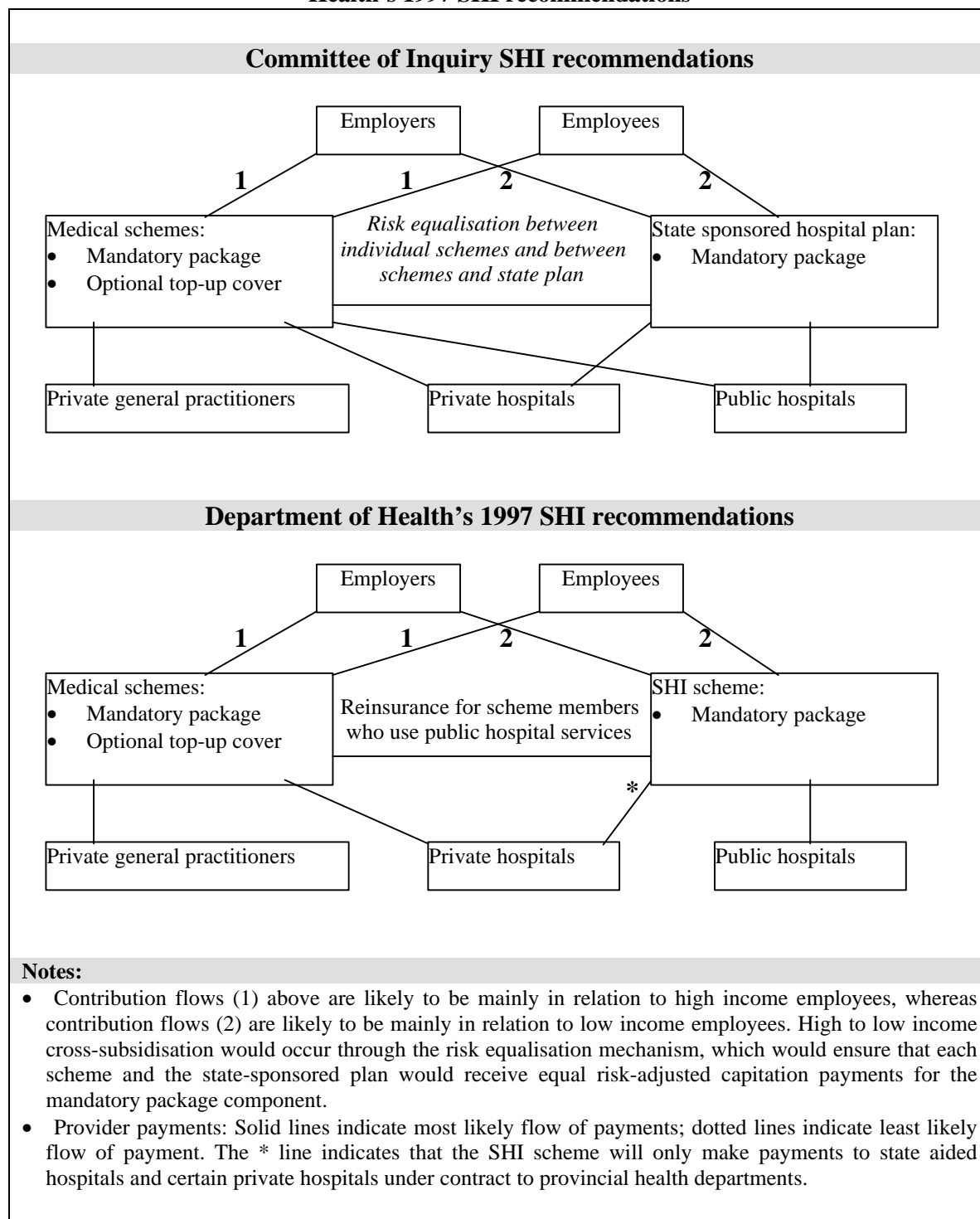
administration of which might be undertaken either by private or state administrators” (South Africa 1995: 73). There would be a statutorily defined minimum hospital service benefit package and income related contributions. As the income related contributions for the statutory package would be the same, irrespective of whether members were registered with a medical scheme or the “state sponsored hospital plan”, a risk-equalisation mechanism would be required. This would mean that if the state plan comprised mainly low-income workers while high-income earners remained within medical schemes, there would be a mechanism for high- to low-income earner cross-subsidisation. There would also be a cross-subsidy from the private sector (through SHI employer and employee contributions) to the public sector (through SHI payment of user fees when members use public hospital services) (see Figure 6.2).

The 1997 SHI proposals also recommended that formal sector employees should have the choice of making their mandatory contributions to either a medical scheme or a state sponsored fund (Department of Health 1997a). However, while the Committee of Inquiry envisaged a risk-equalisation mechanism between all the different SHI financial intermediaries, the 1997 SHI working group recommended a complete separation of the state fund from the medical schemes (see Figure 6.2). Medical schemes would only need to “*reinsure themselves with the SHI Scheme for the expected use of public hospital services by their beneficiaries*” (Department of Health 1997a: 4). Thus, the cross-subsidisation between high- and low-income earners within the SHI structure, as envisaged in the Committee of Inquiry’s proposals, has virtually been removed. A small cross-subsidy will remain **within** the SHI if medical scheme members do use public sector hospitals and pay above cost-recovery levels for these services. It is precisely this lack of cross-subsidisation which has led to opposition from one of the key stakeholders, namely COSATU (see **Chapter 8**). Although members of the working group were aware of the implications of their proposals in terms of reducing the cross-subsidy from high- to low-income earners, they argued that previous proposals did not adequately take the totality of private/public sector cross-subsidies into account. They proposed that one should also take account of tax funding for public sector services as medical scheme members pay tax but do not usually use public sector services. However, if one uses this argument, a full tax incidence evaluation would be required to determine the extent of the cross-subsidy from non-users to users of public sector services and the overall degree of progressivity within the existing tax structure.

Moreover, cross-subsidies within the tax system are unlikely to be substantial given that VAT, which is a highly regressive tax, forms a major component (nearly one-quarter) of total tax revenue. The regressivity of VAT and excise taxes on tobacco and alcohol products to some extent offsets the progressivity of personal income tax. Thus, while the top decile of the population accounts for half of household income and approximately three-quarters of *personal* income tax, it accounts for approximately half of *overall* tax revenue (South Africa 1995). As total tax revenue also includes company tax revenue and certain other revenue not directly linked with households, the overall taxation of households is still progressive. However, given the reductions in both company and personal income tax rates over the past few years (Department of Finance 1999), South Africa appears to be moving away from a progressive tax system. IDASA (1999) noted that the 1998/99 and 1999/2000 budgets’ tax proposals would have a regressive impact on the overall tax structure. In addition, as indicated previously, cross-subsidies in favour of high-income medical scheme members persist through tax deductions on scheme contributions.

The issue of cross-subsidies between the private and public sectors and from high- to low-income earners remains a contentious one. However, if SHI is to address existing health sector inequities, the impact of SHI on overall health system cross-subsidies requires careful consideration when designing future SHI proposals.

Figure 6.2: Cross subsidy implications of the Committee of Inquiry and Department of Health's 1997 SHI recommendations



6.3 Issues to be resolved if SHI is to be taken forward

The previous section has indicated that SHI could potentially address some of the remaining health care financing challenges facing South Africa. However, it has also identified a number of issues that must be resolved if SHI is in reality to improve health system sustainability and equity. These include issues of design (e.g. the inadequacy of cross-subsidies in the 1997 SHI proposals) as well as actor-related issues, and these latter are discussed in more detail in **Chapter 8**. This section focuses on two sets of other issues that must also be considered if SHI is to be taken forward in South Africa. The first set relates to resolving the potential disjuncture between SHI and other policies introduced in the 1994-99 period while the second set relates to the necessity to ensure appropriate sequencing of SHI and related reforms.

6.3.1 Potential constraints on SHI arising from other recent financing policies

A key SHI design consideration is the benefit package that will be covered. While some of the earlier SHI proposals (e.g. Option 3 of the 1994 Health Care Finance Committee proposals) favoured SHI coverage of primary level and hospital care for the insured, the 1995 and 1997 SHI proposals focused exclusively on hospital cover (see **Chapter 4**). The main reason for this more limited benefit package was the free PHC policy. Thus, the Committee of Inquiry noted that:

“the minimum [SHI] benefit package would explicitly not specify coverage for primary care services as part of the minimum requirement, since these would be funded and provided via the publicly funded PHC. Instead, the minimum requirements would be that all employed individuals and their families obtain coverage for at least the costs of their use of the public hospital system.” (South Africa 1995: 72).

The primary concern about confining SHI to hospital services is that of cost-containment within the SHI and allocative efficiency in the overall health system. If SHI members have the option of going to a public sector primary care facility without charge, a private general practitioner by means of out-of-pocket payments or a hospital at the SHI's expense, there may be excessive use of hospital care (particularly given the moral hazard effects of health insurance). Kutzin (1995: 24) has noted that “[a]lthough incentives to consumers based on cost-sharing requirements appear to have some effect in reducing demand, incentives to providers are much more powerful tools for containing costs.” Kutzin (1995) argues that the ‘gatekeeper’ role of primary care providers is particularly important in promoting allocative efficiency and cost containment, which are critical to health system financial sustainability. If primary care and hospital services are funded through different mechanisms, the gatekeeper role of primary care providers will be reduced (Kutzin 1998). The fragmentation of health care funding may in fact create perverse referral incentives. There are mechanisms to address excessive use of hospitals, such as mandatory second opinions or obtaining SHI approval prior to admission (*ibid*). In some countries, such as in Vietnam, doctors are employed by the SHI to evaluate the need for admission and to monitor treatment during hospitalisation (Ensor 1995). However, these measures are likely to increase the administration and other costs of the SHI.

In addition to these cost containment and allocative efficiency issues, a SHI should offer considerable health service advantages over existing access if it is to be supported by those who will be covered. As there are concerns that merely covering the costs of public sector hospitals will not be seen as offering significant service advantages, SHI cover for private sector primary care services may considerably enhance the acceptability of any SHI proposal.

Thus, a more comprehensive SHI benefit package may have a number of sustainability advantages. It is conceivable that there could be considerable political fall-out if a mandated insurance specified cover for the primary care services that the government has previously committed itself to making freely available. However, the fact that the free PHC policy explicitly excluded those covered by medical schemes may provide a loophole. While this exclusion was originally intended for those with **voluntary private** health insurance, it may provide a basis for allowing the development of a comprehensive SHI benefit package. In addition, political resistance to mandated primary care cover is likely to be considerably reduced if such cover creates an explicit entitlement to **privately provided** primary care services (see also **Chapter 8**).

The other recent health care financing policy that could potentially impact adversely on a SHI is the 1998 Medical Schemes Act. As indicated previously, N/SHI was previously always seen as an important mechanism for correcting private sector distortions (see for example van den Heever 1994). However, the development of SHI was de-linked from the preparation of regulatory proposals in 1997 as it became politically more feasible to implement the regulations than a SHI scheme (see **Chapters 4 and 8**). Of particular concern is that the 1998 Act may remove part of the justification for pursuing SHI. As one member of the working group that drafted the 1997 SHI proposals noted:

“Effectively, if you went ahead with the medical schemes regulations as they’re proposed, what you create internally within the private health insurance system, if you force community-rating, is you get risk-sharing and eliminate a huge part of the argument for a national hospital fund.” (interview data).

It is anyway unclear whether the new regulations will be successful in enforcing community rating. As one key informant within the private sector noted in relation to these regulations:

“the whole machinery that has been created by the private sector is capable of bypassing the government legislation. It’s actually capable of doing that now” (Interview data).

If the medical schemes’ industry is able to circumvent these regulations, risk-rating practices will continue to occur, albeit in more subtle and ‘disguised’ forms. Dumping could also persist in new forms, with patients, especially for those suffering from chronic diseases, shifted out of the mandatory hospital care environment into the PHC or community-based sectors. Thus, even if there is not true risk sharing within medical schemes, there will be the appearance of sustainability within a voluntary, community-rated environment that will weaken the argument for a SHI. However, one of the key remaining arguments in favour of a SHI within a community-rated environment is that it would substantially increase the health insurance risk pool.

While there are some concerns about the implications of the 1998 Medical Schemes Act for the future of SHI in South Africa, it should be recognised that this legislation is of great importance in regulating private financing intermediaries, some of whose practices are detrimental to public sector health services. As indicated in other chapters, the drafting and passing of this legislation was a considerable achievement for the national Department of Health. Thus, the key issues are that the medical schemes’ regulation will need to be reconsidered or adapted if and when a SHI becomes a serious possibility – and, in the meantime, its impact on issues such as those discussed above should be monitored.

6.3.2 Sequencing of parallel reforms in support of SHI

Successful design and implementation of complex health sector reforms may be enhanced by appropriate sequencing of specific elements of the overall reform package (see **Chapter 1**). Thus, it may be necessary to put some elements of the reform package in place before other elements of the package can feasibly be implemented. This section considers three specific areas of complementary action required in the South African context if SHI, combined with improved user fee systems at public sector hospitals, is to achieve its full potential in contributing to enhanced health sector equity and sustainability.

Fees at public sector hospitals and SHI

There are a number of ways in which efforts to generate additional revenue through user fees at public sector hospitals and the introduction of a SHI are inter-related. At present, fee levels at public sector hospitals are relatively low and have not kept pace with inflation over the last few years. In addition, they are not strictly enforced either in terms of rigorous means testing (to identify those who are employed and earning an income that would allow them to contribute to the costs of care) or in relation to securing payment of fees that are levied. This is not surprising given that, in most provinces, there is no *effective* retention of fee revenue at facility level or even within the health sector (i.e. in some cases, fee revenue may be retained, but it is merely offset through reduced budgets). Due to the federal structure in South Africa, provinces may determine whether or not to allow retention of revenue at facility level and/or within the health sector. It appears that in some provinces that have rejected fee retention by individual facilities and/or by the provincial Department of Health, hospital fee revenue currently contributes a significant proportion of total provincially generated revenue. In contrast, where hospital fees account for an insignificant proportion of provincial revenue, user fee revenue retention at facility and/or provincial health department level has been approved (interview data).

It has been argued that improved fee structures and billing systems should be implemented **before** a SHI can become a reality (McIntyre 1997a; Monitor Company *et al.* 1996; South Africa 1995). There are two primary reasons for this. Firstly, there is little incentive for those who are currently not covered by medical schemes but would be covered by a SHI (mainly low-income employees) to join an insurance scheme which covers the costs of public sector hospitals. Low-income formal sector employees have reasonably good access to public sector hospitals, given the concentration of these facilities in large urban areas. They currently pay little or nothing for these services and, thus, do not face the risk of incurring substantial costs when using public hospitals (McIntyre 1997a). The Committee of Inquiry noted this problem:

“Under current arrangements, many employees may find it hard to accept that they should be forced to contribute for hospital services that they have hitherto been receiving for free or at very low cost. However, in an environment in which cost recovery based user charges were strenuously enforced, the appeal of a risk sharing arrangement would be much greater” (South Africa 1995: 75).

In recent discussions of SHI proposals with key stakeholders, the largest trade union federation (COSATU) objected to SHI on these grounds (see **Chapter 8**).

The second issue is related to the first: in addition to the need for a risk of incurring substantial costs to exist before insurance is feasible, it is usually also necessary to offer improved quality of services. The international literature suggests that SHI coverage must offer “*significant advantages*” over existing services if it is to be acceptable (Normand and Weber 1994: 20). This issue generated concern throughout the 1994-99 period (see **Chapter 8**) and differences in the

quality of clinical care between the insured and non-insured would, from an equity perspective, be unacceptable (see earlier discussion). Nonetheless, it *may* be necessary to consider offering improved ‘hotel’ inpatient facilities (such as smaller wards, choice of food, access to telephones etc.) and appointment systems or a ‘fast queue’ for non-emergency services in outpatient departments (McIntyre 1997a). Given the existing constraints on public hospital budgets, it would be necessary to generate and retain additional fee revenue in order to initiate these quality improvements before a SHI could be implemented.

These two financing reforms also have a linkage in the opposite direction. It is internationally recognised that the revenue generating potential of user fees is affected by the extent of health insurance coverage within a country (Akin *et al.* 1986; Barnum and Kutzin 1993; McPake 1993). McIntyre (1997a) estimated that fee revenue at public sector hospitals could be nearly doubled if a SHI were introduced and SHI members were charged cost-recovery fees (and increased six-fold if fees nearer to private sector hospital fees were charged) (see Box 6.2).

Thus, there is a ‘virtuous cycle’ between hospital user fees and SHI: improved fee collection and revenue retention could provide incentives necessary for introducing a SHI and a SHI would in turn substantially improve fee revenue generating potential which could be used to further improve quality of care. However, the inter-relationship of hospital user fees and SHI appears not to have been adequately recognised by some key actors and the two have not been considered in a comprehensive, holistic way in any of the health care financing policy documents issued by the Department of Health to date. It would seem that such consideration is essential if South Africa is to find an entry point to this ‘virtuous cycle’.

Hospital autonomy

Strengthening the management autonomy of hospitals is a form of decentralisation that has an important impact on user fee revenue generating potential. In particular, the international literature suggests that health facilities should be permitted to retain a portion of the revenue they generate as a fee collection incentive (Creese and Kutzin 1996; Mwabu and Mwangi 1986; Shaw and Griffin 1995; Vogel 1988). Increased hospital autonomy is seen as a mechanism for improving hospital management, including billing and budgeting systems, which would have a profound effect on user fee revenue generation. Thus, in this instance, organisational reform (i.e. decentralisation) is necessary to support successful implementation of health care financing reforms (i.e. increased user fee revenue generation at public sector hospitals).

The Hospital Strategy Project (Monitor Company *et al.* 1996) made wide-ranging proposals for improved public sector hospital management, within the framework of increased autonomy. User fee revenue retention was also a component of these proposals. By 1999 initiatives had been developed to increase the autonomy of central hospitals through the establishment of performance contracts (interview data). However, no progress appeared to have been made on increased autonomy for other hospitals. Revenue retention by hospitals was also approved in principle by the national cabinet in early 1998, but the final decision was recognised to fall within the jurisdiction of provincial governments. Some provinces have approved that facilities retain a proportion of fee revenue, some have rejected revenue retention and others have yet to decide on this issue (interview data). It appears that the lack of progress on revenue retention is partly due to hospital management capacity weaknesses (see also **Chapter 9**).

Thus, improved financial and other management capacity at facility level, possibly through increased hospital autonomy, is critical to the successful implementation of health financing reforms. Without improved billing and fee collection systems, the potential for increased user fee

revenue, particularly when accompanied by increased insurance coverage through SHI, will not be realised.

Accounting for extra-budgetary resources under fiscal decentralisation

The final issue that should be addressed to support the implementation of a sustainable and equitable SHI is that of creating mechanisms for accounting for extra-budgetary resources within a fiscal decentralisation environment. The main source of extra-budgetary resources in the health sector is that of retained user fee revenue, which would be enhanced if a SHI were introduced. Provinces have differential capacities to generate extra-budgetary resources. For example, provinces containing the major metropolitan areas such as Gauteng, the Western Cape and KwaZulu-Natal potentially are able to generate substantial extra-budgetary resources given that the majority of the formally employed are located in these provinces. This is not the case in poorer provinces such as Mpumalanga, the Northern Province and North-West. This differential revenue generation capacity should be taken into account in a resource allocation formula.

The provincial block grant allocation formula originally proposed by the FFC would have been able to accommodate this issue. The FFC's 'tax capacity equalisation grant' could have been amended to not only account for differential capacity to raise provincial taxes, but also to account for different capacities to generate extra-budgetary resources. However, the Department of Finance formula, which is currently used by the Budget Council in determining the horizontal division, would require considerable revision to account for the differential revenue generating capacity between provinces. Thus, this issue requires further consideration to ensure that extra-budgetary resources generated through a SHI and improved user fee system are equitably distributed.

6.4 Summary and Conclusions

This chapter has reviewed how SHI could potentially address some of the outstanding health sector equity and sustainability challenges in South Africa. However, SHI should not be regarded as a panacea for the ills of the South African health system. Instead, it is one component of a wider health sector reform package that requires further careful consideration and evaluation, particularly in relation to sequencing of the reform package components. Equity and sustainability will not be promoted unless implementation of SHI is preceded by improved hospital user fee systems, enhanced decentralised hospital management and a mechanism for ensuring the equitable distribution of resources available to public sector services. In addition, the SHI itself must be designed specifically to address overall health sector cross-subsidisation issues, the benefits package must offer members significant advantages over current services and efforts must be made to attract SHI members to public hospitals (e.g. through improved 'hotel facilities'). Evaluation of the 1998 Medical Schemes Act may provide useful lessons on behavioural incentives in a mandatory environment. Other reforms, such as the development of an integrated, comprehensive policy on the private sector, are also required to support the development of constructive public-private partnerships. Further lessons regarding developing SHI policy are provided in Chapter 10.

CHAPTER SEVEN INITIATING POLICY CHANGE: COMMON EXPERIENCES	99
7.1 Developing policy during a time of radical change	99
7.2 The central role of actors in policy development	103
7.3 The sources of actors' influence	109
7.5 Limited health economics capacity and understanding in the DOH	115
7.6 Lack of clarity in the equity goal of health policy	117

CHAPTER SEVEN

INITIATING POLICY CHANGE: COMMON EXPERIENCES

This chapter identifies and analyses the key factors that shaped policy design and development in the three reform areas of focus, building on Chapters 3-6. These factors are also integrally linked to the other issues raised in Chapters 8 and 9 as explanations of the pattern and impact of health care financing change. The conclusions derived from their analysis are then linked to the discussion and recommendations of Chapter 10.

7.1 Developing policy during a time of radical change

7.1.1 Taking advantage of a 'window of opportunity'

The overwhelming mandate given by the population to the ANC-led Government of National Unity in 1994 was for change that would redress the inequities of the apartheid legacy. The Reconstruction and Development Programme, presenting the new government's broad policy agenda, reflected that demand and emphasised the importance of health within its agenda. Health gain was seen as a critical element of broader human development, whilst it was judged that the RDP targets could more rapidly be met through health service improvements than through change in other sectors (African National Congress 1994b; interview data; see also Box 7.1)

Box 7.1: Statements on health in relation to broader socio-economic development

"Inequity has a moral dimension, suggesting that there are unavoidable and unjust dimensions of the unequal distribution of health resources. The poorer one is, the more likely one is to be unhealthy, or at least vulnerable to disease". Dr M. Tshabalala first chair, national portfolio committee on health (Republic of South Africa 1994: 3339)

"We must remind ourselves that expenditure on health services is an investment for the future well-being of our people and the future economic prosperity of our country". Dr A. Nkomo, MP, second chair, national portfolio committee on health (Republic of South Africa 1995: 2914)

This general political support for the health sector was translated into specific support for the 1994 ANC Health Plan. The most well developed of any sectoral plan, it commanded substantial respect from the progressive health movement and, through its consultation process, had also gained wider support (as described in **Chapter 4**). The Plan provided the new Minister and her department with a strong foundation for quick action in many areas, including the implementation of free care for pregnant women and children under six and a health sector resource re-allocation formula. With their strong equity orientation these policies fitted well with the broader political imperatives of the time, and so had important symbolic value. Implementation of the first Free Care policy, for example, was seen to reflect the *"need for politically symbolic gestures"* whilst resource re-allocation was *"...high priority and the area that could ... make a difference and be seen to be doing something"* (health policy analysts, interview data). In addition, these policies had the advantage of being easy to implement – or, at least, of being perceived as that. Free health

care could be delivered “*just by saying so*” whilst to achieve resource re-allocation the new health managers seemed to believe that all they needed to do was “... *go in there, wave a magic wand and government would just do something*” (health policy analysts, interview data). They were, in effect, “*simple, sellable policies*” (interview data), that brought political backing and were supported despite criticism of the manner of their implementation (see also **Chapter 9**).

The Department of Health, thus, identified both the first Free Care policy and health resource re-allocation as among its key initial achievements, not only bringing political prestige (see **Chapter 5**) but also part of its action to improve equity and access (Ntsaluba and Pillay 1998). The broader political importance of these policy actions was emphasised by the President in his opening address to Parliament in February 1997: “... *arguably, nowhere else is the fact of democratic transformation felt more keenly than in the area of universal access to health facilities. The building of clinics and hospitals, the immunisation programme and the beginnings of a new drug policy – all these and more are practical and new qualitative steps that have transformed the majority of South Africans from being neglected outcasts into beneficiaries of a compassionate health policy*” (Government of South Africa 1997: 5).

The complexity of both norms and standards and N/SHI policy, in contrast, appeared to be one factor slowing policy action on these issues (see also **Chapter 8**).

7.1.2 Constrained by massive structural change

The radical structural transformation initiated after the election of the new government created, however, an enormously difficult environment in which to develop and implement policies (see also **Chapter 9**). A range of new governance structures came into operation with immediate effect (see **Chapter 3** for more details) because, as noted by an external review of the public service conducted in 1998, the ‘machinery of government’ inherited by the first democratic government of South Africa was fundamentally flawed. It

“... was constructed and managed for purposes of regulation, control and constraint, and not for those of community empowerment and development. The instruments necessary to begin the process of reconstruction and development simply did not exist. A new machinery and a new culture of governance had therefore to be created. The enormity of this challenge cannot be overestimated” (Presidential Review Commission 1998, section 2.1.3).

At the same time, new personnel were recruited into government to help with transformation at both national and provincial levels (see **Chapter 4**). “*Even experienced managers would have had problems in that situation with a total transformation, new policies, new everything*” (health policy analyst, interview data). Although the new officials came to their jobs with innovative ideas, their limited knowledge of the basic functioning of the civil service or government procedures meant that they sometimes “*struggled to win broader acceptance of these ideas*” (Presidential Review Commission 1998, section 2.2.3). Their job was sometimes made more difficult because of inertia within the bureaucracy and the active resistance of some old bureaucrats (Human and Strachan 1996; Ntsaluba 1998). So “*...it was a hell of a learning curve. You get into power then it hits you like a thunderbolt. You don’t know the rules and regulations*” (provincial official, interview data).

Given the nature and scale of these changes, it was not surprising that in some ways “*the act of restructuring undermined the development of functional policy*” (health policy analyst, interview data). Many of the health policy analysts interviewed, for example, criticised the new national Department of Health’s initial failure to set clear priorities for the 1994-99 period, judging that it took on too many, poorly selected issues at the same time (interview data; see **Chapter 9**). In the

process the particularly critical issue of HIV/AIDS, for example, was neglected despite the development of a widely supported national AIDS plan before 1994 (Schneider 1998). In addition, much policy development in the early days of government was shaped by a 'five year mentality', associated with the need to show change before the 1999 elections (interview data). Both analysts and provincial officials involved in developing the 1994 health resource allocation formula, for example, felt that its design and implementation owed more to *"the need to deliver something politically and show it was more re-distributive"* (budget analyst, interview data) than to careful deliberation. The key decision-making process was certainly rather chaotic as *"The way the policy was made was incredibly rushed with people working on computers and hand held calculators ... It was done in a pretty ad hoc way. The decisions were basically made over a week-end"* (Function Committee member, interview data).

The consequences of the speedy development of the 1994 formula included design weaknesses (see **Chapter 5**) and technical confusions that appeared to have continuing influence over the development of health resource allocation approaches until 1999 (interview data). The limited thought given in the original formula to which health functions, or levels of care, should be controlled at national level and which at provincial level, thus, led to a continuing debate over allocations to the major referral hospitals. In the guise of 'conditional grants', this debate became one of the central elements of health resource allocation debates after 1996, in the fiscal federal era. Another concern was that the poor data used in determining provincial health sector allocations in 1994 may have resulted in some provincial departments of health being given inappropriately low financial ceilings from then on (interview data). The weaknesses, and time lags in receipt, of expenditure data were certainly recognised problems (e.g. Brijlal *et al.* 1997; Monitor Company *et al.* 1996) that added to the difficulty of developing a resource allocation formula (see also **Chapter 5**).

7.1.3 Policy shaped by continuing structural evolution

The technical confusions underlying the initial health sector resource allocation formula provided, moreover, a weak foundation for the continued evolution of resource allocation policy. Although health sector structures such as the PHRC and MINMEC demonstrated a high degree of solidarity and co-operation in policy development across provinces over the entire 1994-99 period there was, inevitably, some tension around resource allocation issues (interview data). Relatively under-resourced provinces tended to support actions and proposals likely to ensure additional resources for them, whilst relatively over-resourced provinces tended, of course, to be more cautious (interview data – see also section 7.2). The structural changes brought by fiscal federalism further politicised the process after 1996, giving both provincial Treasuries and health MECs critical roles. By 1998 provincial health officials, thus, judged that *"Resource allocation is very much a political thing now and not a technical thing. It's all about political pressure on the provincial treasury"* and that fiscal federalism *"does away with anything the social services are trying to achieve. Provinces have to fight it out ... there are huge political dynamics. We had a change of MEC ... The new MEC had to learn from the beginning and was a lighter weight politically"* (interview data). Some provincial Treasuries also appear incorrectly to have treated the health conditional grants as part of, rather than additional to, the unconditional provincial block grant, so *"we're never sure if it is additional or not. It could be used to pay the province's deficit, or it could be used to affect the total cash flow problem"* (provincial health official, interview data). The overall result was that there have been some setbacks in the pursuit of financial equity between provinces for the health sector (see **Chapter 5**).

However, problems of resource allocation at provincial level were also a reflection of the newness of the provincial layer itself and the lack of clarity about roles, responsibilities and lines of accountability between layers of government that inevitably accompanied the structural

evolution (see **Chapter 3** for more details). In addition, within the fiscal federal system introduced following the ratification of the 1996 Constitution provincial governments became the accountable unit for government expenditure, instead of individual spending departments, yet remained heavily dependent on inter-governmental transfers for their income (de Bruyn and Budlender 1998). Although constitutionally independent, this fiscal dependence is likely to have given the national Department of Finance considerable leverage over provincial Treasuries and, in turn, to have limited other provincial departments' room to manoeuvre in policy development (see **Chapter 9**). Overall, therefore, even as government technicians began to learn how to manage their new environment, the structural context within which they worked continued to evolve and place new demands on them.

A further element of the post-1994 structural change that shaped budget and policy development was the newness, and so weakness, of the institutions charged with scrutinising budgets and policies. Parliament, for example, still had little influence over budgetary decisions by 1999 because it could only reject, rather than amend, government budgets. Dominated by the ANC the National Assembly was, however, unlikely to take the drastic step of fully rejecting budgets. Budget debates throughout the 1994-99 period, therefore, rarely involved serious budget interrogation but were more about political debate and – some would say - posturing (interview data). In addition, the main 'inquisitor' of health policy development at a national level, the national Portfolio Committee on Health, was undermined by the relative inexperience and limited technical understanding of its members, the majority of whom were new to parliament (see **Chapter 3**; interview data). It also appeared to be ignored by the national Department of Health. Thus, in its 1997 report the Committee itself commented that it was "*still largely uninformed about [policy] developments*" and that "*no information was provided on the task groups [working on SHI and private sector regulation] or further findings or possible implementation*" (Portfolio Committee on Health 1997: 13, 33; see also interview data). Inexperience and broader capacity constraints similarly limited the effectiveness of both the second chamber of the new political dispensation, the National Council of Provinces, which was only created in 1996, as well as the provincial standing committees on health (counterparts to the national portfolio committee) (see **Chapter 3**; interview data). Government departments were, therefore, able to function with only limited parliamentary oversight of their legislative and policy action over the 1994-99 period.

7.1.4 Constrained by macro-economic policy

A final, important part of the ever-changing context of health policy development between 1994 and 1999 was the implementation of GEAR in 1996 (see also **Chapters 3 and 5**). As they began to develop skills and experience in policy development, GEAR introduced what many health policy-makers and managers perceived as new constraints on policy action.

By maintaining a tight deficit target in the face of debt interest re-payments which capture the largest share of the government budget, GEAR may have negative effects on budget availability for the social sectors (Gilson and McIntyre 2000; Heintz and Jardine 1998; May 1998). In addition, GEAR's commitment to reducing the tax to GDP ratio underlay the DOF's opposition to any form of 'earmarked tax' – as it regarded an SHI scheme (section 7.3; see also **Chapters 3 and 6**). Thus the Deputy Director General of the national DOH noted in 1998 that although there had been a re-prioritisation of the budget in favour of the social services, GEAR had limited the opportunities for additional funding (Ntsaluba 1998).

Overall, therefore, transformation of the public health system had to be undertaken within a fiscal environment that required that additional funds for relatively under-resourced levels of care, geographical areas and population groups came from cuts in the budgets of relatively over-

resourced areas (see also **Chapters 3, 5 and 6**). Such a task was inevitably technically and politically difficult as it meant that

“The ANC’s commitment to redistribution can take the form, not of company or income tax rises, but only of service and welfare re-allocations away from the urban middle class to the rural dispossessed and unemployed, and to a lesser extent to the unionised working class. As the middle class increasingly has to pay more for school fees and medical aid, their ‘falling standards’ complaints will be more articulate, and count more with the media and its advertisers, than the voice of the ‘poorest of the poor’ benefiting from improved and accessible primary health care and from schools better equipped and staffed”

(Gottshalk 1998: 129; see also **Chapter 3**).

Conclusions:

- *A time of transformation in national policy goals enabled early health policy action but the accompanying change in personnel, administrative and governance structures also made it, subsequently, difficult to develop well-designed policy;*
- *Change in macro-economic strategy provided a context that constrained the potential for taking forward specific revenue generating and re-distributive health policies.*
- *Information gaps, a failure to set priorities for health policy action and the capacity weaknesses of the structure and mechanisms for political scrutiny of policy-making were further elements of context that influenced the pattern of policy-making between 1994 and 1999.*

7.2 The central role of actors in policy development

The conflictual nature of health policy development in the 1994-99 period was clearly stated by former Minister Zuma in an interview after only two years in office. She commented then that sometimes *“she feels that the ‘enemies of transformation’ she has to fight now are ‘more difficult to deal with’ than those she encountered during the liberation struggle”* (Gevisser 1996: 31). From the perspective of those seeking change, the context and causes of the antagonisms underlying health policy development were well described in 1998 by the ANC chair of the national Portfolio Committee on Health:

“The sheer magnitude of the reform process, the complexity of the inter-relationships and the substantial stakeholder interest, made the implementation of this new system difficult and often conflict-ridden. Health care is now more controversial for the simple reason that it affects us directly every day... For far too long this health system has been allowed to evolve along a path dictated by a combination of commercial interests and narrow, racial prejudice, and with every attempt to change it, we meet face to face with people who profited from this country’s unsavoury past” (Republic of South Africa 1998: 1560).

Although ‘conflict’ might better characterise the nature of broader policy action, particularly pharmaceutical policy reform, actors were inevitably also at the heart of health financing policy development, and differences between interested actors shaped specific policy development processes. The remainder of this section outlines the actors of relevance to health care financing issues and their roles in related policy development processes, and section 7.3 presents a more detailed analysis of the factors that gave key actors influence in these processes.

Table 7.1 illustrates that whereas resource allocation and fee policy development were ‘internal’ to government, primarily involving actors with formal roles in routine government processes, N/SHI policy development drew in a wider range of actors (see **Chapter 4**). The involvement of a wider group of actors was partly driven by the creation of special, ‘one-off’ policy structures that included or consulted actors outside government. At the same time, the N/SHI debates provoked wider debate because the policy of focus had the potential to have a direct impact on the concerns of these actors (see also **Chapter 8**).

The two actors that were most clearly important across all three financing reform areas were the former Minister of Health, Dr Zuma, and the Department of Finance. Dr Zuma was, for example, instrumental in ensuring that the first Free Care policy was included within the 1994 Presidential announcement (interview data), and then made the formal parliamentary announcement of free primary care. Although she had also been a strong supporter of speedy health sector resource re-allocation in the early years of the new government (interview data), the DOF became the key player in all resource allocation developments after 1996. It, in particular, pushed for the hospital focus of the conditional grants that are now being used in the health sector, over the formally stated policy preferences of both the FFC and the DOH (see Figure 7.1). Finally, although the DOF did support fee retention at hospital level in the context of strengthened hospital management (interview data), both Dr Zuma and the DOF were, for different reasons (see **Chapter 8**), important opponents to the various N/SHI proposals.

Figure 7.1: Forcefield Analysis, Conditional Grant 2					
Actor categories	Proponents			Opponents	
	high support	<<<	<<<	Not Mobilised	high opposition
government sector	DOF DOH Hospitals' C/Directorate	PDOHs, urban provinces	DOH DHFE	PDOHs, rural provinces NDOH FFC	
analysts			most not mobilised	some analysts	
political sector			all actors		
business & social sectors			not mobilised		
Notes: <ul style="list-style-type: none"> • The grant of focus here is that covering funding for the ‘ten central hospitals’ (see Chapter 4); • actor highlighted played most critical role • not mobilised = did not play identified role in debates, but this allows for an actor to have played a ‘behind the scenes’ role e.g. resource allocation issues bound to have been discussed within MINMEC but no indication that MINMEC driving policy development in this area • DHFE = Directorate of Health Financing and Economics; DOF = Department of Finance ; FFC = Financial and Fiscal Commission; NDOH = national Department of Health; PDOH = provincial Department of Health 					

Table 7.1: Summary of key actors and their roles in relation to the reforms of focus 1994-99			
	Resource allocation policy	Primary care and hospital fee policy	N/SHI policy development (including medical scheme regulation)
Political sector	<p>Dr Zuma expressed strong support for Function Committee formula, subsequent role not identified MINMEC role not identified</p> <p>Cross-party support for MTEF whilst fiscal federalism accepted as by-product of negotiated settlement</p>	<p>President announced Free Care 1 Dr Zuma pushed for Free Care 1 and announced Free Care 2; involved in hospital fee discussions in MINMEC MINMEC discussed and partially approved HSP proposals on hospital fees ANC support for Free Care 1, and likely for Free Care 2; no clear role on hospital fees</p>	<p>Dr Zuma no direct communication with any committee but clear role in opposing, to varying extent, all proposals except the 'Deeble option'; provided direct support within Cabinet and in discussions with DOF for medical scheme re-regulation MINMEC approved 1997 SHI proposals; discussed medical scheme regulation proposals Main opposition parties opposed Deeble option & concerned about aspects of medical scheme re-regulation ANC favoured investigation of broader social security options instead of 1997 SHI proposals</p>
Government sector	<p>DOH Director General played direct role within Function Committee, subsequently chair of PHRC in which issues frequently discussed DOH DHFE played no role in Function Committee but reviewed its formula as input into FFC proposals; played limited role in fiscal federal era Additional DOH units involved include Hospital Chief Directorate, as conditional grants focus on hospitals Provincial DOHs strongly involved in all discussions through Function Committee and PHRC DOF strongly involved in fiscal federal era, particularly through key role in government budgeting process FFC made proposals on resource allocation approaches under fiscal federalism</p>	<p>DOH Director General supported Free Care 2, involved in hospital fee discussions as chair of PHRC DOH DHFE played very limited role as key decisions taken before unit became fully operational Additional DOH units involved include Hospital Chief Directorate on hospital fee issues DOF not directly involved (but formal role in relation to e.g. revenue retention policies) Provincial DOHs had limited role in Free Care policies but directly involved through PHRC in hospital fee discussions</p>	<p>DOH Director General involved in support of, or within, all special committees DOH DHFE participant in all special committees, most active in 1997 Medical Schemes Working Group Provincial DOHs only involved through discussion of SHI proposals in PHRC DOF member of COI and involved in discussion of 1997 SHI and Medical Scheme Working Group proposals</p>
Business sector	no position taken	no position taken	<p>Medical schemes body (RAMS) directly involved in special committees 1994-5, and consulted by 1997 Medical Scheme Working Group; split within whole insurance industry over medical scheme regulation Other private sector interests made submissions to COI and were consulted by some other committees</p>
Analysts	<p>SA analysts involved through critical evaluation of policy proposals undertaken outside routine structures of government, or as consultants to parliamentary committees or other government bodies</p>	<p>SA analysts directly involved in HCFC and HSP policy discussions, but otherwise limited role</p>	<p>SA analysts directly involved in all committees, but consistently opposed by Dr Deeble</p>
Social sector	<p>COSATU called for more transparency in budget process in fiscal federal era Media often dramatised the resource allocation issues through reporting on 'negative' impacts</p>	<p>Media raised concerns about implementation practice & effects</p>	<p>COSATU consulted by COI and SHI Working Group; opposed to 1997 proposals Some media expressed opposition to Deeble option & 1998 Medical Schemes Act</p>

Political actors other than the former Minister of Health appeared to play only limited roles in all aspects of health care financing policy development. Whilst the health MINMEC often discussed the issues, its approval of the 1997 SHI proposals, for example, was apparently offset by Dr Zuma's continuing caution – perhaps itself reflecting broader caution within the ANC (see **Chapter 8**). Other political parties either broadly accepted policy developments, such as the general shape of budgeting and resource allocation policy in the fiscal federal era, or had little opportunity to shape policy development in reflection of their stated concerns. They were neither directly involved in the structures that made decisions nor were they able to exercise influence through parliament given the ANC's dominant position within it and the weaknesses of parliamentary oversight mechanisms (section 7.1; see also **Chapter 3**).

The governmental actors other than the DOF involved in health care financing policy development differed by policy area. The Financial and Fiscal Commission (FFC) only had a formal role in resource allocation policy development whilst the provincial Departments of Health (PDOHs) and national DOH Chief Directorate of Hospitals were more actively involved in resource allocation and hospital fee policy development than in N/SHI policy development. In contrast, the Directorate of Health Financing and Economics (DHFE) had quite limited roles in relation to resource allocation or fees' policy but was actively involved in N/SHI policy development.

The diversity of views within 'government' on policy issues is, moreover, highlighted by the different positions of these actors on specific policy proposals. Thus, whilst the DOF and DOH Hospital's Chief Directorate favoured the hospital focus of several of the conditional grants, along with some, more urban, provinces, other, rural provinces were more cautious. Differences between provinces over the conditional grant for the central hospitals, for example, partly reflected their differing views of the likely impact of these grants (see Figure 7.1). The PDOHs in more urban provinces generally supported them because their facilities received financial protection, although they were also concerned that the grants would reduce their ability to allocate resources between academic hospitals and other health services. PDOHs in more rural provinces, however, were concerned that this grant would limit the potential for resource re-allocation between provinces, even whilst welcoming the grants supporting tertiary care development (interview data). Overall, however, the hospital focus of these grants contradicted the stated policy preference of both the FFC and the national DOH for protecting primary care funding in resource allocations (hence the conflict highlighted in Figure 7.1 between the NDOH as a whole and the DOH Hospitals' Chief Directorate). The FFC had, for example, proposed that a 'district health service' component be used in determining provincial unconditional block grants (Financial and Fiscal Commission 1996). As this FFC proposal was not implemented, the 1997 White Paper on the Transformation of the Health System later stated that an alternative mechanism needed to be found to protect PHC funding at provincial level from "*local political pressures acting in favour of high technology hospitals*" (Republic of South Africa 1997: 43; also interview data).

Table 7.1, in addition, highlights the different positions on N/SHI of the Directorate of Health Financing and Economics and the national DOH's two Director Generals over the 1994-99 period, in comparison with the Minister of Health at the time. These civil servants were clearly more supportive of both the 1995 and 1997 SHI proposals than the Minister, and indeed the 1995 proposals were produced by a committee co-chaired by the then Director General (interview data; see also **Chapter 8**).

The main actors outside government who were involved in N/SHI debates but not in other aspects of health care financing policy development were the Trade Unions and the private health sector.

The Trade Unions, as represented by COSATU, broadly supported the 1995 SHI proposals when directly consulted but then opposed the 1997 SHI proposals (interview data; see **Chapter 8**). Interestingly, some suggest that opponents of the 1997 proposals may have explicitly sought COSATU's reaction to them in the correct expectation that their objections would become a factor preventing their implementation (interview data).

The position of the private health sector in these debates was more complex because there are a diverse range of private health sector interests - including insurers, providers, employers that either contribute to employees' health costs or offer their own health care services and the pharmaceutical industry. Whilst the insurance industry was an important actor, and played formal roles, in N/SHI policy debates, other private health sector interests took a less explicit role, making submissions to relevant committees but not directly participating within them. They were also less clearly co-ordinated than the insurance industry. For example, a diverse range of provider and employer groupings made submissions to the 1995 Committee of Inquiry. These included several independent practitioner associations and province-specific primary care provider groups, national groupings such as the National Association of Private Hospitals and the Medical Association of South Africa, as well as the South African Chambers of Mines and Business and the American Chamber of Commerce in South Africa.

However, even within the insurance industry, different groups also presented different positions on N/SHI-related issues at different times. The traditional and main form of insurance cover in the South African private sector has been provided by 'medical aid schemes', that is, non-profit, employer-based, voluntary insurers (see **Chapter 3**). Until 1996 these schemes came together in a fairly cohesive grouping, the Representative Association of Medical Schemes (RAMS). However, the private insurance industry split during the 1990s in response to changes in the market environment that had been prompted by the de-regulation of the insurance industry in the early 1990s. A new form of insurance product provided by the life assurance industry became popular and a new industry organisation, the Concerned Medical Schemes group (COMS), emerged from within the life assurers' camp in the mid-late 1990s.

Before 1994, RAMS actively sought to shape N/SHI policy development through its early dialogue with the progressive health movement, for example, in the development of the ANC Health Plan (interview data; see **Chapter 4**). RAMS' representatives also participated in both the 1994 Health Care Finance Committee and the 1995 Committee of Inquiry and broadly supported the SHI proposals of both 1995 and 1997 (see **Chapter 8**). It also came to accept the regulatory proposals of the 1997 Medical Schemes Working Group. This apparently conciliatory approach towards government on the part of the insurance industry, however, changed markedly with the arrival of COMS. Worried about the direction of government policy, COMS actively opposed and lobbied against the 1997 regulation proposals. The consequent split in the insurance industry then reduced its policy influence (see also **Chapter 8**). However, the emergence of a new body in 1999, the Board of Health Care Funders, may allow the industry to take co-ordinated and firm action in the future to protect its interests.

Health policy analysts and economists working outside government played active roles in various aspects of health care financing policy development with variable influence. Some of the South African analysts had direct impact on the development of the 1998 Medical Schemes Act as participants in the group developing new legislation and, as discussed in **Chapter 4**, Dr Deeble influenced N/SHI debates. However, neither the criticism of resource allocation policies, including conditional grants (see Figure 7.1), by South African analysts, nor their support for the various sets of SHI proposals (see **Chapter 8**), led to the policy changes that they favoured.

Although the extent to which the media directly influenced health care financing policy appears also to be limited, some newspapers consistently publicised issues in each reform area. Their reporting not only contributed to the personalised nature of health policy debates (see Box 7.2) but also, at times, helped to create a ‘high pressure’ atmosphere that may have shaped policy development. For example, the reaction of both the more business-oriented and more progressive newspapers to discussion of the ‘Deeble option’ and to the initial terms of reference of the Committee of Inquiry, was seen as a factor ‘encouraging’ the Minister to accept changes to the latter Committee’s focus (see **Chapter 4**). Reviewing health policy debates over the 1994-98 period, the then Deputy Director General of the DOH, thus, suggested that the Department had “*challenged fundamentally the comfort zones of a variety of stakeholders. On many occasions we witnessed the establishment of strange alliances and the use of the media in a very negative way, not so much to challenge the policy positions .. but more to create an impression of general recklessness in the speed of implementation and the conjuring of the worst images of post-liberation Africa*” (Ntsaluba 1998: 5).

Box 7.2: Media reporting on health policy conflicts

“Who would have thought Nkosazana Zuma new Minister of Health ... would raise blood pressures in the business and financial communities quite so quickly?” **Financial Mail** May 27th 1994

‘Zuma Plunges Into Renewed Controversy’ **Financial Mail** March 22nd, 1996

“Health Minister Nkosazana Zuma hit back at her critics of her proposed health reforms yesterday and said the legislation would go ahead despite opposition and threats of legal action from the pharmaceutical industry” **Business Day** September 19th 1997

‘Zuma Stands Firm Despite Criticism’ **Finance Week** October 31st 1997

“Running through all of these controversial initiatives have been changes to SA’s medical policy which have systematically disempowered stakeholders and concentrated power in the hands of a totalitarian minister” **Finance Week** November 6th 1996

‘Zuma or Health Care: Time Now to Choose’ **Citizen** March 30th 1998

‘Step Down Yourself Instead of Passing the Buck, Zuma Told’ **The Star** May 12th 1998

Finally, as Table 7.1 indicates by omission, there was little or no involvement of other civil society groups, including health workers or the broader public, in any area of financing policy (see also **Chapter 8**).

Conclusions:

- *Dr Zuma and the Department of Finance were influential across all health care financing reform areas;*
- *government actors were more influential in resource allocation debates and specific interest groups more influential in N/SHI debates;*
- *civil society organisations, including research units, had limited influence across debates and the public was rarely directly consulted.*

7.3 The sources of actors' influence

7.3.1 Dr Zuma's political status and values

The former Minister of Health's central role in all aspects of health policy development between 1994 and 1999 was clearly partly a reflection of her formal and pre-eminent role, as Minister, in the process of policy development (see **Chapter 4**). Dr Zuma's policy actions were, moreover, given legitimacy by the ANC National Health Plan and subsequent policy documentation, and she also derived influence both from the position of Minister within the dominant party of the government, the ANC, as well as from her own political profile. As a 'loyal cadre' of the ANC she was not only consistently supported by the Party but also, personally, by the President and Deputy President over the period. Some suggest that her high political standing within the ANC was reflected in her appointment in 1999 as the Minister of Foreign Affairs in the second ANC government. Nonetheless, as a central member of the new government's 'policy elite' (Grindle and Thomas 1991), she also personally shaped the pattern of health policy change in pursuit of her own values and concerns. Thus one government official noted, *"if you know what the Minister wants you can see what will go through ... this is very personalised decision-making and it's much more difficult to get her support for things she's not interested in"* (interview data; see also Box 7.3).

An important factor contributing to Dr Zuma's pre-eminent position in health policy development, therefore, was her own clarity of purpose in seeking to improve access to health care for the poor and rural populations in the face of the apartheid legacy. Her clearly stated goal was a *"health service that is accessible to everybody and more equitable"*, rooted in the concern that *"... there are people who are dying every day. There are people who should have had (health) services years ago. There are people who are putting all their hopes on this government to solve their problems"* (Interview with Minister Zuma, *The Star*, November 3rd 1997). Her strong commitment to children and women was often evident and was generally said to be a product of her own clinical experience: *"She is both a steely activist and a committed professional in the field of her own portfolio. If you have any doubts about the latter, ask her what it's like to watch a child die under your care unnecessarily due to a lack of facilities"* (Gevisser 1996: 33).

Dr Zuma's direct role in implementing the two Free Care policies, and her support of the health sector resource allocation formula are, therefore, not surprising. In direct contrast, however, she said in 1996 *"I'm not committed to health insurance. The most important thing is to bring free health care to the people: if we can do it through taxation, then that's preferable"* (Gevisser 1996: 33). Thus, analysts involved in the SHI debates suggested that Dr Zuma had *"...an ideological problem with the logical outcome of the plan that we've been proposing since the ANC health plan"* (health policy analyst, interview data). (See also **Chapter 8**). For some, the former Minister's choice of policies also simply reflected her excellent political instincts. According to this view she prioritised policies that would have clear gains for the population, recognising the need *"to make limited gains in particular areas"* (interview data). Rather than seeking radical change in health care structures and funding patterns she, therefore, favoured specific initiatives such as the Free Care policies. Action on these issues, moreover, enhanced her political profile because, as she said herself *"...if it did not happen within 100 days it would have had a lot of negative impact. I could not stop it, because once the President had announced it, people wanted to utilise it the very next day"* (Interview with Minister Zuma, *The Star* 3rd November 1997; see also **Chapter 5**). Others, however, argue that Dr Zuma and her senior civil servants did not set clear priorities and did not prioritise some of the most important issues (interview data; see also section 7.1; **Chapter 9**).

These factors explain Dr Zuma's personal influence over health care financing policy development and the broader policy community (see **Chapter 4**). They allowed her to withstand the pressures created by the enormous personal and highly publicised criticism targeted at her during her term of office (Box 7.2), as well as to pursue policy directions despite repeated 'advice' to the contrary, as with N/SHI (see **Chapter 8**).

Box 7.3: Views of Minister Zuma

Interview data:

- *"resilient and tough"* (private sector analyst, interview data).
- *"a hatchet man and a bulldog – I wouldn't have wanted to work under anyone else"* (provincial health official, interview data)
- *"what matters to her is not what people think, but what the truth is"* (policy analyst, interview data)

Weekly Mail and Guardian profile (Gevisser 1996):

- *"unfashionable but powerful; willful and driven; self-contained, diffident and sometimes downright crabby; possessed of an astonishing economy of motion ... that masks an equally astonishing capacity for action: she kicks, as they say, ass"*

South African Medical Journal 88(1), January 1998

- *"Health Minister Nkosazana Zuma assumed office in 1994 with a passionate mission to transform South Africa's health care system from its apartheid model to an equitable, affordable, acceptable and accessible health care system for all South Africans by the year 2005. In this she will not be deterred even if in the process, and of necessity, she is obliged to step down on a few toes."*

The Sunday Times January 3rd 1999

- *"she has a string of achievements that cannot be matched"*

7.3.2 The Department of Finance's driving forces

In any government the department or ministry that guides macro-economic policy and controls government budgets is inevitably in a dominant position to influence the policy and actions of 'spending' ministries, such as health. In addition, the Department of Finance derived both political and economic influence from its central role in developing and implementing the government's flagship macro-economic policy framework, GEAR. GEAR had the personal backing of two of the most influential figures in the first ANC government, the Minister of Finance and the Deputy President (*Africa Confidential*, 28th August 1998; interview data), and provided a clear vision of the government's economic goals and strategies. The DOF, thus, became the most influential central government department after 1996, taking firm positions across all aspects of government policy development.

The touchstone for its positions and decisions across sectors was, inevitably, GEAR and its underlying vision of the appropriate role for government in South Africa. Some suggest that this vision reflected a quite narrow neo-liberal perspective in which the State should focus on providing basic services to the poor. Others are more cautious, suggesting that the DOF's strong belief in the market was tempered by a clear commitment to equity – but that its approach to achieving equity differed from that proposed by others (interview data). This latter opinion is supported by the expressed views of DOF officials, highlighted in Box 7.4, which demonstrate a strong neo-classical economic approach to welfare issues.

Box 7.4: Views on health policy issues from the DOF

- the public health sector will never be what high income groups want in a 'developmental state' and for the low income, health care is less important than other services because *"as people get poorer, health services lose out in some sort of welfare maximising evaluation relative to other things"*
- *"government looks after basic needs, but complements what households can afford and choose for themselves"*
- as households have a greater capacity to meet some part of the costs of basic care than of hospital care, there is an important role for government financing of specialised and costly care

Source: interview data

In any case, the driving goal for the DOF across all social sectors was the pursuit of efficiency in public sector resource allocation and use - as part of the broader strategy for controlling public sector expenditure levels and reducing the government deficit (Department of Finance 1996; Gilson and McIntyre 2000; McIntyre and Gilson forthcoming). The 1997 review of health sector allocations by the MTEF task team, for example, explicitly analysed these allocations primarily in terms of efficiency, overlooking the issue of inter-provincial equity (see **Chapter 4**; Department of Finance 1997; McIntyre *et al.* 1998). Rather than accepting the need to increase health or other social sector budgets to allow transformation, a common view was that *"the mentality behind the thinking at the DOF is that there is much wastefulness at the provincial level so they can do more with less, squeeze them to make them more efficient"* (government health official, interview data).

The DOF was, therefore, specifically concerned to improve provincial budgeting practices in ways that contributed to efficient resource use, and so was supportive of mechanisms introduced to improve co-ordination between provincial Treasuries and health departments, such as the 1998 'four by four' (interview data). In addition, whilst the protection afforded to central hospitals through the health conditional grants was partly a response to concern about the potential collapse of the public hospital system, it may also have reflected the DOF's view of government funding priorities for the health sector (and efficient resource allocation patterns). Reflecting Box 7.4, by 1998 DOF officials suggested that further re-allocation between levels of the health system in favour of primary care was not necessary (interview data).

GEAR's objectives, including its efficiency goals, also underlay the DOF's opposition to the differing N/SHI proposals of the period. It criticised the broad range of the 1995 Committee of Inquiry proposals, for example, because they assumed too optimistic levels of spending for the health sector. Then it opposed the 1997 SHI proposals because they represented an unacceptable increase in the national tax burden in the face of GEAR's tax to GDP targets (interview data; see also section 7.1.3; see also **Chapter 3**). Rather than allowing earmarked tax revenue to be retained by the collecting agent, the DOF insisted that it should be seen as part of the common tax pool and so be brought into the usual channels of budget decision-making and, in theory, be subject to parliamentary oversight (interview data; see also **Chapters 6 and 8**).

A final source of the DOF's policy influence was perceived to be its internal technical capacity and success in policy development, as well as a particular style of action. *"There was definitely an incredible arrogance in the DOF and they viewed themselves as a kind of level above other government departments. And people came to them for approval, and they said yea or nay and then the other people went back and did things accordingly"* (health policy analyst, interview data).

7.3.3 Contrasting the private health sector and the Trade Unions

The two key non-government actors who had influence on N/SHI policy development were the private health sector and the Trade Unions.

The roots of the insurance industry's involvement in the SHI processes lie in the willingness of RAMS to engage in the pre-1994 debates about a future health care system for South Africa. It was, in part, *"caught up in the euphoria of the new government and in the vision of expanding access to health care and in the vision of the private sector supporting that health care initiative"* (private sector analyst, interview data). Yet at the same time, it entered into debate with what it saw as the *"moderate wing of the radical movement"* (health activist, interview data) at that time, in order to secure the industry's place in the future.

The continued involvement of RAMS in policy development after 1994, therefore, represented a strategy to gain influence over policy development, grounded in the view that it was *"better to be there so that one can participate ... than be out of it, to just allow the process to go ahead"* (HCFC committee member, interview data). The main driving force and goal of this strategy was protection of the medical scheme administrators' *"unique vested interest. The vested interest was essentially to expand the number of lives covered through the medical schemes movement in a way that they had customised their business to address"* (HCFC committee member, interview data). It was, in other words, concerned to protect the commercial interests and profit margins of the medical scheme administrators. In pursuit of this goal RAMS developed a dual strategy of participation in the committees, drawing on its own technical knowledge of the issues, combined with informal lobbying and advocacy with senior policy-makers outside the committee structures. It seems likely that it drew on its broader economic status in 'encouraging' the media to publicise its views (interview data), and, perhaps, to gain access to policy-makers. Although the former Minister of Health was sceptical about the private sector's role in the health sector, the broader economic policy environment was unexpectedly open towards business interests (see **Chapter 3**).

As noted, however, its role in policy development was undermined by the split within the private health insurance industry during 1996-7 and the emergence of a new actor, COMS, from the life insurers' segment of the industry. This split seems to have been, in particular, a factor facilitating the passing of the 1998 Medical Schemes Act (see also **Chapter 8**).

COSATU, in contrast, had only limited economic influence as well as very little technical capacity to engage in policy debates on N/SHI. Its potential influence to these debates was, instead, derived from its political status. As a core member of the Triple Alliance, it was closely tied to both the ANC and the South African Communist Party and played an important role in shaping the RDP, if not GEAR (see **Chapter 3**). When consulted on the 1995 Committee of Inquiry proposals, therefore, the COSATU leader supported the proposals but *"in effect all he was saying was COSATU supports the government. It's an ANC Ministry. It's an ANC minister. We support her. If she says it's a good thing then we support her"* (policy analyst, interview data). However, by 1997 some of COSATU's affiliates, individual trade unions with most interest in the issue, had developed a clearer position on health care financing issues. They specifically opposed SHI proposals because of concern to protect members' interests as well as to achieve broader social goals (interview data; see **Chapter 8**). Their concerns may, therefore, have been fed into high level political discussion on these proposals between the ANC and the trade union movement. Some interviewees, for example, suggested that some sort of informal alliance between the trade unions and Dr Zuma, based on similar reservations about the proposals (see **Chapter 8**), may have underlain the 1997 ANC Conference's preference for investigation of broader social security reform in which SHI would be only one component (interview data).

7.3.4 Summarising actors' different sources and levels of influence

Drawing on the earlier analyses of individual actors, Table 7.2 seeks to explain the differences between actors in their general influence over health care financing policy development in relation to the level of influence each derived from five potential sources. The actors included in the Table were partly selected to ensure that all categories of actors were considered, and either because they played influential roles in these debates or their failure to influence policy development was in itself important.

The possible sources of influence identified in the Table are:

- *political status* - derived from the new 'political dispensation' ushered in by the 1994 election of the first democratic government of the country and, in particular, from closeness to the party that won that election by a huge margin, the ANC;
- *economic status* - largely derived from an actor's independent wealth base or from an actor's potential to influence wealth creation and the resource base of other actors;
- *formal policy position* - derived from the actor's formal role in government policy development processes, including specific health policy processes, after 1994;
- *knowledge* – derived from the actor's analytical skills and understanding of health economics and financing issues;
- *values/behaviour* – derived from the actor's clarity of purpose and/or tactical behaviour in relation to policy development.

Table 7.2: The sources of actors' influence over health care financing policy development						
actor	overall level of influence	source of influence				
		political status	economic status	formal policy position	knowledge	values/behaviour
Political:						
Dr Zuma	high	√√√		√√√		√√√
Government:						
DOF	high	√√√	√√√	√√√	√√	√√√
DHFE	low	(√)		√	√	
PDOH	low	(√√)		√√		√
Business:						
Insurance industry	middle		√√√	√	√√	√√
non-government analysts:						
South African	low	√		√	√√√	√√
Dr Deeble	middle	(√√)		√	√√√	√√√
social sector:						
COSATU	high	√√√	(√)			√√
Notes:						
<ul style="list-style-type: none">• number of ticks indicates relative level of influence derived from source, 3 ticks = high; 2 ticks = middle and one tick = low; no tick = no influence derived from this source• brackets = indirect influence derived from this source• COSATU = Congress of South African Trade Unions; DHFE = Directorate of Health Financing and Economics						

As already discussed, the two most influential actors, Dr Zuma and the Department of Finance, derived their influence in policy development largely from a combination of political status and formal policy position as well as from clarity of purpose and tactical behaviour in policy debates (section 7.3.1-2). In addition, the DOF also had significant economic status because as the driver of macro-economic policy after 1996 it strongly influenced the national economic environment. Thus, it influenced the potential of other actors (e.g. the business sector) to maintain and create wealth, or the resource base of other actors (e.g. government departments and provinces). Although it derived some further influence from its technical skills (particularly in relation to general economic analysis rather than health sector analysis), knowledge appears to have been relatively unimportant as a source of influence over health care financing debates in the 1994-99 period. Thus, neither of the two groups that had health economics' knowledge relevant to health care financing debates were strongly influential within them. The DHFE had a weak, but developing, skills' base in this period but was also undermined by a variety of other weaknesses (see section 7.4). At the same time, the non-government South African analysts rarely managed to build on the influence derived from either their strong technical capacity or their strategic action, to achieve the policy changes they favoured (see also **Chapter 8**). Meanwhile, Dr Deeble's influence over N/SHI policy debates seems to have been derived more from a combination of the former Minister's support for his policy position (see also **Chapter 9**), giving him indirect political influence, and his own conduct within formal policy processes, than from his own technical knowledge. He was, for example, described as "*a consummate corridor politician*" (interview data) who had no hesitation in using informal mechanisms to access and seek to influence the Minister.

The influence of PDOHs over resource allocation policy development, and, indirectly, their political status, was largely derived from their formal policy position as key actors within the provincial governments that became the accountable unit for government expenditure after 1996, i.e. the agents given constitutional responsibility for health care delivery. In addition, they were able to exercise some influence over the shape of the health conditional grants through their co-operation in the PHRC in developing a nationally agreed policy, despite tensions between them over the issues (as discussed in section 7.2). Thus, although "*there are agendas ... national and provinces do have a shared vision*" (central government official, interview data). However, their general level of influence in these debates was specially constrained over the 1994-99 period by the concurrent evolution of the governance structure of the country (see section 7.1; **Chapter 3**).

Finally, as discussed in section 7.3.3, the private health insurance industry and the trade unions derived their influence over N/SHI policy debates from very different sources. The private health insurance industry developed a dual strategy of direct participation and informal lobbying in pursuit of its commercial interests, drawing on its economic status. But its support of both the 1995 and 1997 SHI proposals did not ensure policy implementation. In contrast, it appears that COSATU may have used its close political links with the ANC to feed into a broader wave of opposition to the 1997 SHI proposals, thus helping to block their further development.

Overall, therefore, this analysis suggests that actors derived their influence within the health care financing policy arena in the 1994-99 period largely from three particular sources – political status, formal policy position and values/behaviour. Although economic status was also important to some actors on some issues (specifically N/SHI) it appears to have been a relatively unimportant source of influence in health financing policy development. This may partly reflect the fact that several components of health care financing policy were developed within government – rather than within the broader policy arena. The important potential role of economic power as a source of influence in policy debates is not, therefore, contradicted by this analysis of a particular set of experiences. The development of pharmaceutical policy in the same

period, for example, was the subject of particularly intense opposition from the pharmaceutical industry, doctors and pharmacists who all perceived that their commercial interests were significantly threatened by the policy (Ntsaluba 1998). The pharmaceutical industry even used its economic status to leverage both domestic and international political support for its opposition to the policy. Yet the ultimate failure of these strong-arm tactics only emphasises the broad conclusion derived from financing policy development. As the then Deputy Director General of Health noted in 1998, “... in our situation forward movement has required strong political leadership and commitment...[as] ... some stakeholder interests are completely irreconcilable with the goals of equity and the public health perspective” (Ntsaluba 1998: 10, 13).

Conclusion:

- *strong political leadership was important in health care financing policy development;*
- *personalised decision-making was one explanation of the picture of policy development, in that policies that matched the values of policy leaders and elites were implemented but those that did not, were not;*
- *knowledge was relatively unimportant in health care financing policy development but tactical behaviour did contribute to actors’ influence.*

7.5 Limited health economics capacity and understanding in the DOH

The DOH’s Directorate of Health Financing and Economics could, in principle, have been expected to be an important actor in health financing policy development, deriving influence from the political and positional importance of the Department of Health as a whole as well as from relevant knowledge and skills. In practice, however, its influence over the 1994-99 period was quite weak. Although it is widely accepted that the Directorate played an important role in keeping health care financing discussions alive (interview data), its main impact on health financing policy was through the passing of the 1998 Medical Schemes Act. Policy development processes in this period were more often driven by other actors’ views. The DHFE was, instead, brought in after key policy decisions had been made (e.g. Free Care), sought primarily to co-ordinate others (e.g. inputs to the budget process), or played a supporting role (e.g. in relation to N/SHI special policy processes). The lack of progress in developing norms and standards for use in resource allocation in the fiscal federal era reflects the weakness of the Department as a whole, and the Directorate within it, in financing matters. Several factors underlie the weak policy development role played by the Directorate.

The DHFE was only established as part of the re-structured DOH in 1995 and only really became a functioning unit in 1996. These early days of government were a time of immense institutional change as new people came to new jobs and sought both to transform structures and policy (see section 7.1). The DHFE initially provided analysis to persuade the DOH that free primary care would not lead to large revenue losses, and provided inputs into the FFC’s preparatory work for the fiscal federal era by reviewing the Function Committee’s formula (interview data). However, a particular problem affecting the DHFE role at this time was that “*People in the government, starting from the Minister and the DG ... had little understanding of some of these [financing] issues*” and “*..certainly there was not a tradition of that in the Department of Health at all*” (health officials, interview data). The consequences for the Directorate included being treated like accountants, merely responsible for managing budgets, as well as having to educate colleagues on

financing matters through the process of policy development (interview data). Perhaps not surprisingly, the former Minister and her Department were criticised for having an approach summarised as *“decide on health policy and then organise the financing”* (government official, interview data) and for its inability to internalise and absorb international experience, research and information (interview data). A particular concern to many analysts outside government was the DOH's initially very limited understanding of the powerful private sector, leading to policy views that were initially *“uninformed and crude”* (health policy analyst, interview data).

The Directorate's role in policy development over most of the 1994-99 period was also undermined by its own organisational position within the DOH. Reflecting the general lack of understanding of financing issues, it was initially established at a quite lowly position within the overall DOH structure: *“when the department was being structured health financing was never thought of as an important issue ... If the people who were conceptualising it had some idea of the importance they would have put it visible, either as a programme – now its not a programme, it's a sub sub programme”* (government official, interview data). As a result of its organisational location the head of the DHFE was not formally involved in the Department's strategic decision-making – although financing issues are clearly important to those decisions. As the Director's immediate supervisor had no background in, or understanding of, financing issues, the DHFE was more often guided in its work by the Deputy Director General (DDG) for Policy and Planning. Yet the DDG's position prevented him from getting involved in the detail of many issues and the DHFE was blocked in its action when he was occupied by other demands (interview data). A further reflection of the DHFE's weak position within the DOH appears to be that the policy on conditional grants was, rather, driven by the Hospital Chief Directorate. Overall, therefore, the Directorate's position was *“severely affected by the fact that it's not a Chief Directorate for health financing issues ... it's affected their ability to do things in parallel. Where there are issues that are important, some five or six issues, in health financing, they've only handled them in sequence rather than in parallel”* (health policy analyst, interview data). As a result of these types of problems the Directorate was moved in 1999 to the Chief Directorate of Financial Management and Administration, which is otherwise responsible for the DOH's own internal budgeting and accounting. It remains unclear whether this new position will enhance its effectiveness.

Other organisational factors undermining the Directorate's influence included the lack of structures through which more junior civil servants could timeously and regularly update the Minister on policy matters. *“Sitting with the Minister is quite difficult, there simply isn't a structure for her involvement at an early stage”* (government official, interview data). Even on budgeting issues, which are central to the normal functioning of any department, the Minister was said to be *“the last person to be informed”* (government official, interview data). These problems may also have been exacerbated by the screening function of certain senior Ministerial advisors (interview data). So, when given direct access to the Minister in preparing her to present the medical schemes' re-regulation proposals in Cabinet in 1998, Directorate staff made a positive impression on her and, generally, raised the profile of their unit (interview data).

Finally, although the task of health care financing policy development is multi-faceted and complex, ideally requiring a sizeable team of skilled practitioners from different fields, the Directorate only had a limited number of posts. In addition, given the general lack of health economists in the country, those appointed to positions within the Directorate were quite inexperienced and had mostly relatively narrow commerce or economics backgrounds. In contrast, for example, the DOF had skilled staff who took forward their policies in ways that enhanced their influence. Not surprisingly, therefore, DHFE staff members were initially quite uncomfortable in dealing with the DOF (interview data). One strategy adopted to address these

sorts of capacity constraints was to involve economists from outside the DOH in, for example, the small groups developing policy around SHI and medical schemes' regulation in 1997. The government's general reliance on external consultants between 1994 and 1999 led some to suggest that this slowed its own internal capacity development (Presidential Review Commission 1998; interview data). However, the process of developing the medical schemes' regulations, in particular, enabled DHFE staff to develop an understanding of the private sector that will be important for future policy development. This process also brought prestige and enhanced the profile of the Directorate both within the DOH and the broader policy community (interview data; media reports). This experience is a clear example of the gradual strengthening of the DHFE over the 1994-99 period that will provide an important foundation for future health care financing policy development.

Conclusion: the initial weaknesses of health economics understanding and capacity within the DOH as whole undermined careful agenda-setting on health care financing issues and the development of health care financing policy; but the Directorate of Health Financing and Economics' skill base and experience clearly grew stronger over time.

7.6 Lack of clarity in the equity goal of health policy

One of the primary goals driving all health policy after 1994 was clearly 'equity' – but policy documents suggest that there was limited clarity on the nature of this goal. In practice, various definitions of equity underlay policy statements. Box 7.5, for example, outlines the variety of equity goals and objectives identified within the 1997 White Paper for the Transformation of the Health System in South Africa, the main health policy statement of the period.

Box 7.5: Equity goals established in the 1997 White Paper for the Transformation of the Health System in South Africa (Republic of South Africa 1997)

Overall vision for the health sector includes that it will:
play a part in promoting equity within society as a whole by developing a single, unified health system;

Specific health system equity goals include:

(a) for health care delivery:

- making universally accessible an essential package of primary health care interventions
- an emphasis on reaching vulnerable groups such as the poor, the under-served, the aged, women and children with health care services
- re-allocation of personnel between rural and urban areas

(b) for health care financing:

- re-allocation of funds between rural and urban areas
- re-allocation of funds between people served by public and private sectors
- improved degree of cross-subsidisation to allow improved access to good quality care for unemployed and poor

The overall vision established for the health sector places the health system within the context of the broader societal equity goals established within the RDP. Creating a single, unified health system might appear, therefore, to reflect an equity goal of using the health system as one mechanism of creating broader social solidarity within a previously fragmented society. Thus, the Chair of the National Portfolio Committee on Health stated in 1998 that, “A key principle, underlying all current health policy, is that of reinforcing social justice. This is intended to ensure that where health care is concerned, people will be allowed, as far as is possible, to contribute financially to the health system according to their means, and to use services according to their need” (Republic of South Africa 1998: 1562).

However, the more specific equity objectives established to guide the health system’s functioning appear sometimes to reflect a narrower understanding, as well as to be potentially contradictory. For example, the first health care delivery equity objective, achieving equal access to an integrated package of primary care for the whole population, appears to reflect an equity goal of equal access for all – and, perhaps, equal access to only a (limited?) package of primary care. Yet, the second health care delivery equity objective emphasises the intent to target improved access towards identified vulnerable groups, that is to benefit preferentially some groups through the health care system. Whilst both can be justified as equity goals they are more narrow than that established in the overall vision for the health system in that they focus only on improving – presumably, although not clearly stated – geographical access. Improving access to a limited package of primary care for all, moreover, may still allow the more wealthy to buy additional care as they desire – perhaps then using more services than they ‘need’ as well as maintaining relatively greater access to care than those who cannot afford such ‘top up cover’ (see also **Chapters 6 and 8**). This possibility reflects an important broader criticism of the potential equity impact of essential packages (Gilson 1998a), and highlights the importance of considering both access and payments together when considering equity. In addition, the two objectives are contradictory in terms of their expected beneficiary group. Is the intent to benefit the ‘dis-advantaged’ by improving access for all, or to target improvements only on the dis-advantaged? In either case, the identified groups are defined in terms (rural, women, dis-advantaged) that may allow socio-economic differentials in health and health care access to be ignored (Gilson and McIntyre 2000).

The equity goals established for health care financing include consideration of resource allocation across geographic areas and between the public and private sectors. Whilst the health care delivery goals appear to focus on the delivery of public care, the latter emphasises the critical need to consider both the public and private sectors in seeking health system equity (as also emphasised in **Chapter 6**). As noted above, however, it remains unclear how equity in financing side might be linked to equity in delivery, nor how to bring about equity within and between the two sectors of the health system. The established goals are simply too broad to assist in more detailed planning for the promotion of equity.

This confusion and lack of clarity in equity goals was only exacerbated by the vagueness with which the term was used by key actors and the apparent differences in their understanding of the concept. It seems likely that it have provided a weak foundation for policy development – particularly complex policies such as N/SHI (see **Chapter 8**).

<i>Conclusion: lack of clarity in the health policy equity goal may have constrained aspects of health care financing policy development.</i>

CHAPTER EIGHT THE STALEMATE IN SHI POLICY DEVELOPMENT	119
8.1 Complexity of SHI policy design and poor clarity of policy objectives	119
8.2 The interaction between actors and policy design	120
8.3 Weaknesses in the strategies applied within SHI policy development	127
8.4 Failing to engage in public debate	136
Annex 8.1: Data sources for analysis of actor positions on N/SHI options	137

CHAPTER EIGHT

THE STALEMATE IN SHI POLICY DEVELOPMENT

This chapter analyses some specific factors that explain the experience of SHI policy design and development partially considered in Chapters 6 and 7. It provides some immediate conclusions that are then linked to the discussion and recommendations of Chapter 10.

8.1 Complexity of SHI policy design and poor clarity of policy objectives

The diversity of objectives that were associated with the range of N/SHI proposals developed over the 1994-99 period is summarised in Table 8.1. They point both to the complexity of this area of policy change and the evolution of policy design over time (see also **Chapters 4 and 6**). One analyst suggested, for example, that the 1997 SHI proposals were bedevilled by the fact that “many people in the department [of health] did not understand them or how they would work – they were complex and it was unclear how they were put together” (interview data).

Although concern for equity appears frequently in the documentation about these different proposals, the exact nature of ‘equity’ being sought through N/SHI is seldom spelt out, and a certain murkiness often remains around the beneficiaries of improved services. For example, has equity been improved when more people have better access to care, even when the differentials in society are large? (Category 3 proposals imply ‘yes’, whether Category 1 and 2 proposals imply ‘no’ whilst avoiding the issue of the feasibility of achieving equitable cover across the whole population.) And, how does one estimate what is an equitable share of income to pay towards health care cover (i.e. what levels prevent illness becoming a catastrophic event in the financial affairs of the household)? And, what is the essential package of care to which everyone should have access in order for society to be satisfied on equity grounds? Importantly, the 1997 SHI proposals accept - and propose - a lesser reduction in inequity than earlier proposals on the grounds that higher income earners are already unfairly required to pay both towards tax-funded and insurance-funded health care (see **Chapter 6**). In addition, sustainability, in the form of revenue generation, appears to have become a more fundamental objective underlying these proposals.

Specific consideration of these N/SHI equity objectives, thus, only further illustrates the broader lack of clarity around health policy equity goals (see **Chapter 7**). The failure to agree a set of objectives between some of the most important interested actors represented an obstacle to SHI development (see **section 8.2**). Moreover, the complexity of SHI design (see **Chapter 6**) may itself have diverted the proponents of the different proposals from systematically examining their likely impact on equity. By not initially formulating clear objectives, it then became impossible to benchmark policies systematically to assess whether the changing design proposals still ensured that the original goals could be achieved.

Conclusion: the complexity of N/SHI design, and the associated lack of clarity in policy objectives, were important factors underlying the slow progress in developing SHI proposals and contrasted with the perceived ‘simplicity’ of removing fees or implementing a health sector resource allocation formula

Table 8.1: The objectives of S/NHI proposals			
Objective	Category 1 (1988/89)¹	Category 2 (1990-94) includes HCFC²	Category 3 (1996-present) includes COI and SHI WG³
Ideological objectives			
Further the ideological aim of controlling the private sector, and creating a centrally-funded system	Yes	No	No
Equity-related objectives			
Increase horizontal equity through expanding privately funded coverage of older, sicker and poorer beneficiaries	Yes	Yes	Yes
Increase horizontal equity through expanding public sector coverage through diverting resources currently spent in the private sector (i.e. diverting premiums from medical schemes)	Yes	Yes	Yes for COI No for SHI Working Group
Increase vertical equity through improving cross-subsidisation of the richer by the poorer	Yes	Yes	Yes (but to a much lesser extent in 1997 proposals)
Efficiency-related objectives			
Improve the cost-effective use of resources by creating appropriate incentives for the private sector (i.e. allocative and technical efficiency)	Yes	Yes	Yes
Sustainability objectives: Financial			
Find additional resources for the public health sector	Yes	Yes	Yes
Prevent unexpected and unnecessary burdens on the public sector i.e. dumping	not recognised?	Yes +	Yes ++
Sustainability objectives: Political			
Find a politically acceptable way of raising additional resources	Yes	Yes	Yes (very influenced by this need)
Pave the way for an eventual state-funded system	Yes +++	Yes ++	Yes + (extent of commitment unclear)
Note: the detail of these different categories of proposals are outlined Chapters 4 and 6 .			

8.2 The interaction between actors and policy design

Actors played important roles in the evolution of N/SHI policy design, as that design sought to respond to the concerns of some actors. These concerns are summarised for the full range of potentially affected actors, and the various sets of both pre and post 1994 proposals, in Table 8.2 (see also **Chapters 6 and 7**). This analysis has been undertaken by triangulating evidence from a variety of sources, including earlier analyses of stakeholder interests as well as interviews conducted for this study – and the strengths and weaknesses of these different sources are summarised in Annex 8.1. It should be noted at the outset that understanding is most limited for Trade Unions, employers and the public in general. The Unions appear rarely to have publicly voiced their views or presented structured and clear arguments, whilst there have been no opportunities for public opinion to be organised and represented (see also **section 8.4**). Although employers did get involved in some processes, the uncertain perspective outlined for them in the table reflects the lack of clarity in the details of policy design.

In the Table the black cells (with white writing) indicate actors opposing proposals, the grey cells (with black writing) indicate neutral actors and the white cells (with black writing) indicate supporting actors.

Table 8.2: Actor positions in relation to different N/SHI design options

INTEREST GROUP	N/SHI OPTION				
	Category 1 (1988/89)	Category 2 (1990-94)		Category 3 (1996-present)	
		HCFC preferred option	HCFC Deeble option	COI	SHI WG
Private health care providers • GPs	threatened as very small role envisaged for the private sector, implying a loss of patients	potentially supportive as options included the use of private providers which would have secured some clients and income; however, adopted cautious response as extent of the advantages was unclear	strongly opposed as interpreted as 'nationalisation', requiring GPs to be employed by the State with probable adverse impacts on income and independence	not affected because cover did not include PHC, although the COI's report did include proposals for contracting of accredited private providers for PHC care which would have benefited GPs	not affected because cover did not include PHC, except that would not now have benefits of SHI
• Private hospitals			neutral as there was no direct benefit or disadvantage, but the concept of 'nationalisation' would have caused concern	potentially supportive of this option for the same reasons as those under the HCFC preferred option	neutral as there was no direct benefit or disadvantage, but would have queried why patients were not allowed to use private hospitals
Financial intermediaries • Medical schemes	threatened as very small role envisaged for the private sector, suggesting that medical schemes would become defunct	supportive as a much bigger role envisaged for schemes as the intermediaries for NHI, leading to increased stability for schemes (through larger risk pools) and increased profits for administrators (through increased membership size); however, did feel that NHI (as opposed to SHI) was unaffordable and unfair to the tax-payer	probably opposed as the role for medical schemes in SHI was removed, membership for PHC cover would have been lost, and the proposal was seen as an attack on the private sector; also would have had difficulty controlling hospital referral patterns	supportive of this option, for the same reasons as for the HCFC preferred option, except that had expected PHC cover to be the focus of SHI cover	position not clear – would not have got the benefits of most earlier proposals because no longer had a role to play; however, the closely linked Medical Schemes Act had secured the pre-eminent role of schemes in private care
• Life assurers	<u>not yet emerged as actors in the health insurance industry</u>		opposed to anything that would erode the possibilities for cream-skimming: although opposition was mainly channelled against the Medical Schemes Act, 1995 and 1997 SHI proposals were also implicated as antagonistic to Life Assurers' interests		

INTEREST GROUP	N/SHI OPTION				
	Category 1 (1988/89)	Category 2 (1990-94)		Category 3 (1996-present)	
		HCFC preferred option	HCFC Deeble option	COI	SHI WG
Employers					
• Big business	generally against nationalisation and increased taxation	anxious about implications for wage bill and therefore profitability of business, and were therefore against increased taxation and expenditure on health care as a proportion of GDP; however, were cautiously supportive of expanded health care coverage for the employed as long as there was a direct link to health care benefits			
• Small employers		probably anxious about implications on wage bill and therefore profitability of business, which are potentially more risky for small than large businesses (but not very public in their opposition)			
• Government			cautiously accepting of SHI as a desirable policy, but anxious about the financial impact on itself as an employer – these concerns raised at the time of COI and pushed by the DOF		
Potential beneficiaries					
• Organised labour	ideologically in favour of nationalisation and supportive of NHI as a mechanism for providing universal health cover, whilst at the same time motivating for increased medical scheme cover for members as part of wage negotiations with business	accepted limitations of nationalisation; still saw SHI as a mechanism for improving benefits to union members (and, through cross-subsidisation, to wider society), particularly as proposals still provided cover for PHC and hospital care, and allowed the use of private providers	unclear what position adopted on this option: might have been attractive as union members were pushing to get access to private GP cover, and the option also fitted in with earlier ideological positions of centrally-planned, state-run services (including cross-subsidies to the unemployed); however, hospital benefits were not included which would have disadvantaged union members	not clearly mobilised but probably supportive of this option as it offered hospital benefits to union members (including private sector usage) and also included attractive ideas for expanding PHC coverage through private sector providers; there may have been some concern that cover for private PHC services had been lost, and that union members may also have opposed wage deductions for SHI	opposed this option, ostensibly because it severely limited benefits to members, by limiting risk pools (and cross-subsidisation), separating the SHI scheme from the medical scheme environment and by requiring low-income workers to pay for hitherto free care whilst excluding private hospitals; there may also have been continuing concern that cover did not provide members with access to private GPs

INTEREST GROUP	N/SHI OPTION				
	Category 1 (1988/89)	Category 2 (1990-94)		Category 3 (1996-present)	
		HCFC preferred option	HCFC Deeble option	COI	SHI WG
<ul style="list-style-type: none"> The public (users) 	neutral on most options, probably because of the complexity and lack of clarity in the proposals; would expect that the most supportive would be those benefiting most from the policy (the indigent and low-income earners, presently uninsured), some middle-income earners facing lower premiums, the old and the sick, especially in urban areas; also opposition from high-income earners and many middle-income earners would be expected to fall off towards the later SHI options because the cross-subsidisation to low-income workers achieved by later options is much less (and possibly non-existent); opposition by low-income workers can therefore be expected to increase across the options				
The new government <ul style="list-style-type: none"> Minister of Health 	ANC leadership broadly supportive of proposals	Dr Zuma opposed (see discussion in text)	Dr Zuma supported as it brought private GPs under government control, gave universal access and provided PHC cover, which she saw as a paramount priority; she may also have felt that this proposal both met the needs of organised labour, an important political ally of the ANC	Dr Zuma opposed to this policy for the same reasons as for the HCFC preferred option	Dr Zuma less antagonistic to this option because it cut out opportunities for the private sector, but still deeply concerned that it did not meet union needs (e.g. in the form of access to private GP cover)
<ul style="list-style-type: none"> Department of Finance 	<i>not yet emerged as an actor</i>	consistent opposition (see discussion in text)			

INTEREST GROUP	N/SHI OPTION				
	Category 1 (1988/89)	Category 2 (1990-94)		Category 3 (1996-present)	
		HCFC preferred option	HCFC Deeble option	COI	SHI WG
South African non-government analysts and government technicians	the core group of analysts involved in developing N/SHI concepts from the late 1980s, through the ANC Health Plan and on until the COI proposal, consistently supported these proposals		the core group consistently opposed this proposal because it was seen to be financially and politically unfeasible	the core group supported this proposal, with some reservations about the exclusion of PHC from the benefit package	a new grouping of technicians and analysts put forward these proposals, with some internal differences on their linkage to Medical Schemes Act; other analysts were also concerned about the separation of the SHI scheme from the medical schemes environment, the exclusion of private providers from the scheme, and the exclusion of PHC from the package

Summarising the position of each actor, *private providers*, first, were opposed to the very early proposals for NHI as it was placed at the heart of plans to create a centralised, state-run health sector with an extremely limited role for the private sector. After then, however, providers had a neutral or cautiously favorable response to SHI perhaps as a result of the accommodation of private sector interests by the ANC Health Plan (itself part of the general trend within the negotiations preceding the elections). An exception was the ‘Deeble option’ which reverted to earlier beliefs that the private sector should be nationalised and led GPs to believe that the Health Plan concessions had been in bad faith. Thus, whilst the design of SHI proposals does not seem to have changed in order explicitly to accommodate provider interests, the ‘Deeble option’ was certainly steered away from because it represented a major assault on GP interests.

The design of SHI was much more sensitive to the needs of *private financial intermediaries* and, in particular, medical schemes, apparently both because they were seen as possessing the skills to run an SHI and were a mechanism of achieving control of the sector (including private provider behaviour). At the same time, as discussed in **Chapter 7**, the medical schemes pursued their vested interests through their engagement in these policy debates. They, in particular, sought to contain costs and improve risk-sharing, thereby stabilising the private sector and increasing the long-term viability of private sector coverage as well as maintaining profit margins. RAMS’ influence over policy development may be demonstrated by the fact that later proposals broadly coincided with those of its submission to the ANC Health Plan – which proposed that the pool covered by social/private insurance should be increased in order to free government funds to be used for the poor, and that an insurance package be mandated for use by all insurers (Magennis 1994). However, the sector was clearly split after 1995-6, with life insurers then opposing any attempts to regulate the industry and limit ‘cream-skimming’. Although, as noted, the lack of detail in the proposals makes it difficult to determine the position of *employers*, including government, a major concern would have been the impact on the wage bill. This was, in turn, related to issues such as contribution levels and the extent to which SHI would replace (possibly at a cheaper price) existing medical scheme contributions, how future tax benefits to employers from these contributions would be structured and what impact SHI cover would have on industrial relations.

Whilst the position of *organised labour*, in the form of Trade Unions, is not well-documented, there is evidence of support for options that allowed cross-subsidisation between different groups in society. Thus, the COSATU representative’s submission on the 1997 White Paper on Health to the parliamentary portfolio committee on health included the comment that “*if medical scheme members did not contribute, social health insurance would be funded solely by low income earners. This would place a huge burden on them and limit the amount available through the scheme to improve public health services*” (*The Star*, March 23rd 1998). Furthermore, members of the 1997 SHI Working Group noted that “*... the way they [COSATU] put their case is that they want much more cross-subsidisation in the context of their social wage so everyone has a basic safety net ... if you focus only on those not currently covered by a medical scheme, then the scope for cross-subsidisation is substantially reduced*” (interview data). Trade Unions must, however, generally also meet the demands of their membership – and in South Africa these have included increasing their access to private care, particularly GPs, and minimising extra deductions from wages if these deductions do not bring marked improvements in access and the quality of care. Thus, although most N/SHI design options seemed, on the surface, to benefit Union members it is likely that they fell short in a number of key areas (e.g. by not providing access to private care, and not providing additional benefits over and above those already available). Thus, the 1997 SHI proposals were further criticised because “*COSATU couldn’t convince themselves that members should pay for services that they haven’t paid for in the past*” (government official, interview data). This concern, finally, highlights the potential for different responses to any proposal from employees at different income levels. Whilst the 1997 proposals were least threatening to

high- and many middle-income earners, not altering the status quo for these groups, they provoked a negative response from low-income workers who would have been required to start paying for care. The views of other members of the *general public* are, as noted, largely unknown (see also **Chapter 7**; section 8.4).

Although both broadly opposed to the post-1994 proposals, the two main actors of the new government had quite different positions. In contrast to ANC leadership's broad support of the pre-1994 proposals, *former Minister Zuma* was clearly cautious towards all post-1994 SHI proposals except the 'Deeble option', for which she was the main, almost only, supporter. Two main factors appeared to underlie this caution – and so to provide important explanations for the general failure to implement an SHI scheme. Firstly, most of the proposals would have introduced 'tiering' within the public health system, offering the insured a different level of care from the uninsured. Yet her own publicly-stated 'bottom lines', as reported in an early press conference, started with universal and non-discriminatory access to quality PHC for all (van der Linde 1995; see also **Chapter 7**). Not surprisingly, therefore, the only N/SHI proposal that really convinced the Minister was the 'Deeble option' which sought to incorporate private GPs into the primary care system and to fund universal access to PHC through a compulsory and centrally controlled mechanism. As observers noted, "*The Minister is I think a purist about equity and the Deeble option's great virtue is that it is one tier*" (health policy analyst, interview data). It also seems likely that Dr Zuma's position also reflected the broader concern of the new government to achieve racial justice - seen as achieving equality in all spheres of life – in the face of the apartheid legacy of racial bias in all aspects of policy. As stated by an ANC parliamentarian, "... *no one should have the right through his personal wealth to secure better or faster health care in our new society*" (Republic of South Africa 1995: 2914).

Concern for tiering appeared, secondly, to be associated with great caution about the direct role proposed for the private sector within most of the post-1994 proposals. Given that Dr Zuma was said to regard making a profit from health care as "*repulsive*" (health policy analyst, interview data), it is not surprising that her reaction to the SHI proposals of the 1995 Committee of Inquiry was to ask "*how on earth do we get people to buy the package through medical schemes which are falling apart, are very costly and we don't even like them ideologically*" (government analyst, interview data). On both these issues Dr Zuma also appeared to reflect the probable concerns of many within the Trade Union movement. Given that her primary policy focus was to strengthen primary care services, a third, and final factor that may have influenced Dr Zuma was the hospital focus of proposals after 1995 (interview data). However, as the problems of the public hospital sector became an increasing focus of discussion, for example, in the MINMEC, the advantages of an earmarked tax to provide extra funding to support action to tackle these problems were likely to have become more obvious over time.

The *Department of Finance's* opposition to all SHI proposals was largely rooted in concern about their affordability, their contravention of the limits imposed by GEAR on taxation levels and government spending and a general dislike of earmarked taxes (see **Chapters 6 and 7**). Thus a Department of Finance memorandum (1995: 7) states that "*by considering the imposition of user charges ... resulting revenue increases need to be offset by tax reductions elsewhere, because the ... intention is not to indirectly increase the overall tax burden. ... [this] would entail the reduction of hitherto National Revenue Account [i.e. general tax revenue] appropriations to a line department with the same amount that is to be raised through the imposition of charges.*" Other concerns raised by the DOF over time included: the lack of conceptual coherence between health insurance proposals and other social security benefits; the increased government regulation/control that SHI implies; that an SHI scheme would raise the effective tax burden on what was identified as an already highly taxed middle income group; and that it would impose too great a burden on the government as employer given public spending restraints (Working Group on N/SHI 1997; interview data). Although

seen to require much more conceptual and design work, the 1997 SHI proposals were, nonetheless, seen by the DOF as a basis for further discussion. They moved the debate closer to the broad form of SHI scheme that it was willing to consider, described as a “*regulated, in some sense state-sponsored extension of the [private] health insurance industry in the direction of greater coverage for low income earners through standardising packages and lowering transaction costs*” (DOF official, interview data).

Finally, *the core group of non-government analysts* involved in N/SHI development included some that had initiated analysis before 1994 and some that only became involved after 1994. *Government technicians* only took a lead in SHI debates in 1997. Together, however, these actors were instrumental in designing and re-designing SHI proposals, in the face of the former Minister’s continued support of the Deeble option and the DOF’s consistent opposition to the very notion of an SHI. Yet, whilst their later proposals apparently sought, in particular, to offset the opposition of the DOF whilst maintaining the support of the medical schemes, they failed to capture the support of key actors such as the Trade Unions and Dr Zuma.

Conclusion: Policy design had an important influence over actors’ positions around SHI proposals. Whilst changes in SHI design over time appeared to reflect the particular concerns of some actors, and so gain their support, other actors blocked SHI development and implementation because their concerns were not addressed by these changes.

8.3 Weaknesses in the strategies applied within SHI policy development

The profoundly political nature of the process of SHI agenda-setting and policy development over the 1994-99 period provides the setting against which the experience of the three special committees through which the proposals were developed must be analysed. The failure of these committees to lead to an implemented policy is clearly rooted in the opposition of key actors in the ruling political alliance to aspects of the proposed design (see section 8.2; **Chapter 7**) – at a time of radical political and structural change (see **Chapter 7**). A critical question that this finding poses for the actors that sought reform is: why did the relevant policy development processes, that is the special committees, fail to generate SHI proposals that had the support necessary to enable and sustain their implementation?

8.3.1 The gap between policy-makers and non-government analysts

Figures 8.1 and 8.2 highlight one of the most critical issues in SHI policy development – that two actors who might, in principle, have been expected to be allies in developing SHI policy were, in practice, in opposition. The non-government analysts that played a critical role both in the development of the pre-1994 proposals and the ANC Health Plan were, after 1994, key architects of the various SHI proposals that the ‘new’ Minister of Health consistently opposed.

Figure 8.1: Forcefield Analysis, 1995 SHI proposals (COI)						
Actor categories	Proponents			Opponents		
	High Support	<<< <<<	non mobilised	>>> >>>	high opposition	
Political sector			political parties		Minister of Health	
Government sector	DOH DG, DHFE				DOF	
Business sector		RAMS	private providers	employers		
Analysts	Some analysts		some analysts		Dr Deeble	
Social sector			all groups, including COSATU			

Figure 8.2: Forcefield Analysis, 1997 SHI proposals						
Actor categories	Proponents			Opponents		
	High Support	<<< <<<	non mobilised	>>> >>>	high opposition	
Political sector	MINMEC		Political parties other than ANC		Minister of Health ANC	
Government sector	DOH DDG DHFE		DOH DG		DOF	
Business sector	RAMS		Employers; Private providers		[COMS]	
Analysts	Some analysts		some analysts		John Deeble	
Social sector			other groups		COSATU	

Notes:

- Actors highlighted played most critical role
- Not mobilised = did not play identified role in debates, but this allows for an actor to have played a 'behind the scenes' role
- For Figure 8.1, the Committee of Inquiry's overall set of proposals were very wide-ranging, including: free primary care at the point of use; consideration of the role of the future District Health Authorities; accrediting private practitioners to allow them to play a role in primary care provision; mechanisms for ensuring specific funding of primary care and review of the different options for mobilising additional funding for primary care. The SHI-related proposals fell within a set of proposals on regulatory reform of the private sector that were considered even though outside its terms of reference.
- COMS = Concerned Medical Schemes group; COSATU = Congress of South African Trade Unions; DG = Director General; DDG = Deputy Director General; DHFE = Directorate of Health Financing and Economics; RAMS = Representative Association of Medical Schemes

Taking the perspective of former Minister Zuma, the resulting ‘stalemate’ between these two sets of actors has been described by one health policy analyst involved in the processes as a

“... serial experience of putting this [SHI] back to experts whomever they be - at times they change the composition of the team - and they keep coming back with stuff she doesn’t like. So what I think has happened as a result is that she’s increasingly developed a distrust for technical experts and even for a large numbers of her officials for, as they’ve been in the job they’ve learned the job - they’ve gone native - so to speak, they’ve gone along with what the technicians have said” (interview data).

At the same time, from a different analyst’s perspective, the experience has been very frustrating because:

“you could go on analysing the options until you’re silly – there’s so many options, so many directions that you could go in, that you need say here, in concept, we’ve got a direction, can we get agreement that this is the way to go, so we can actually analyse the detail of the option – but until somebody actually gives you a go ahead, there’s no point doing any further analysis, or going into any depth, it’s a complete waste of time because enormous amounts of work will be cast away at one decision” (interview data).

Whilst the last description appears to suggest that this analyst felt that the critical weakness of the process lay with the failure of senior policy-makers to provide adequate guidance, it also points to a critical weakness on the part of the analysts. They *“concentrated on policy and forgot the power and the politics”* (policy analyst, interview data). As policy-making is in essence a political rather than technical matter, those pursuing reform must act politically as well as undertaking technical analysis.

Perhaps the roots of the problem lay partly in an assumption that the health care financing policy agenda for the new government had, in effect, been established through the ANC’s National Health Plan (see **Chapter 4**). Some of the analysts had played central roles in developing the financing proposals of the Plan and so may have assumed that the new government’s first steps in this policy area would be to develop more detailed designs and implementation plans. In contrast, those who became the health policy-makers of the new government had had little or no engagement with the pre-1994 financing debates and brought both different understandings to the post-1994 debates and specific political goals. As one analyst commented, *“... a huge issue which underlies recent history is to do with that kind of break point, of ‘outsiders’ being appointed to the top ... positions [in the DOH] and really having to start again because they didn’t really trust the people or the work that had been done”* on financing issues before 1994 (interview data).

At the same time, former Minister Zuma and her new senior civil servants were seen as particularly concerned to *“take personal charge”* of policy-making in 1994 and *“to put [their] personal stamp on things”* (interview data). The Health Care Finance Committee of 1994 was, thus, tasked with considering the same set of financing issues previously discussed in the ANC Health Plan, working as an advisory, rather than policy-making, body (interview data). Whilst the analysts complained that this was *“re-inventing the wheel”* (interview data), the process was strongly driven by the political objectives of the new Minister: *“...for the better part of the debate she [the Minister’s special adviser] didn’t bother about the technicalities. She had a political objective, she wanted to see clever people deliver the mechanism, but at the end of the day she wanted to know that the political objective was achieved”* (interview data).

From the very start of the post-1994 SHI policy development processes, therefore, it appears that the analysts did not adequately take the new policy-makers’ political goals into account in

the process of SHI policy development. Yet, as sections 8.1 and 8.2 highlight, the complexity of the policy and the need for agreement on objectives made such a foundation essential. Two particular technical lines of argument that from the beginning required debate with policy-makers were (see also **Chapter 6**):

1. securing additional funding for public hospitals through an SHI scheme could enable the release of funds from this level of the health system to support primary care (Dr Zuma's stated concern), and strengthen the financial sustainability of the whole public health system;
2. some degree of tiering of 'hotel care' in public hospitals could act as an incentive to attract high-income paying patients who could be charged at full or above cost rates, in order to generate revenue which could be used to cross-subsidise the care provided to lower income patients at both/either hospital or primary care levels (Dr Zuma's stated concern).

Perhaps assuming that they were the natural allies of the new government in this policy area and shared an understanding of how SHI could contribute to their common goals, the analysts neglected to develop the political support necessary to justify and enable the more detailed technical work that was the major focus of their input to SHI policy development.

Conclusion:

- *analysts failed to establish broad agreement on policy objectives with health policy-makers as a foundation for detailed N/SHI policy development;*
- *the lack of ownership of N/SHI proposals by health policy-makers blocked policy development.*

8.3.2 The weaknesses of the special committee processes

The gap between policy-makers and non-government analysts around SHI policy development played itself out through the operations of the special committees that were established to enable policy development and, in particular, through the debate within them around aspects of the 'Deeble option' first introduced in the HCFC (see **Chapter 4**).

There were clear differences in the three bodies, as highlighted by the differences in their 'primary purposes' (see Table 8.3). As already noted, the new health policy-makers specifically sought to use the HCFC to develop their own policy agenda, and, despite its more political and consultative orientation, continued this effort through the COI. Whilst this agenda appeared to focus on free care, section 8.2 indicates that the underlying preference was for some form of universal health care system. Table 8.3 also provides details of some of the key actions intended to shape the design and functioning of the HCFC and COI. Membership of both the HCFC and the COI, for example, was clearly controlled. Indeed, after the dis-agreements over the 'Deeble option' within the HCFC, and the press leaks of its report, "*a careful filter*" was applied to membership of the COI to try and ensure that no analyst from the HCFC became a member of the new committee (interview data). Although not fully successful, only three of the fifteen members of the COI were analysts, compared to seven out of thirteen in the HCFC and three out of six in the SHI WG. In addition, although originally intended to be chaired by an analyst alone, the COI came to be co-chaired with the then Special Adviser to the Minister. The terms of reference of both the HCFC and the COI were also defined in ways that reflected the political goals and needs of the 'new' policy-makers. Not only was the HCFC tasked with considering the financing issues previously discussed in the ANC Health Plan but it was also required to work behind closed doors. "*The Minister said that ... the government made policy, and this was an advisory committee, and it*

tied her hands and made it harder for her to make policy if the committee produced a public report that she wanted to disagree with (HCFC member, interview data). Later interventions within the HCFC by the Special Adviser to the Minister also sought to ‘encourage’ it to recommend both free care and the ‘Deeble option’. Over time, there was “*less information on what was needed, and more information on what it had to look like*” (HCFC member, interview data). Similarly, the COI members were told to design “*... any kind of system you like as long as it gives you access to primary health care*” (interview data).

In contrast to these earlier bodies, technicians from the Department of Health established the SHI Working Group as a much more focussed, low profile body intended to function over a short period only. Yet it again came to be influenced by the former Minister. First, although initially intended to develop the detailed design of an ‘SHI for public hospitals’ its actual terms of reference also required it to re-consider key aspects of the ‘Deeble option’ (such as universal contributions and access to private GP care). Second, “*the process lacked continuity*” as “*a lot of things just hung in the process*” because of Dr Zuma’s caution about the issues it was exploring (health policy analysts, interview data).

Table 8.3: Factors shaping the special committees’ design and functioning			
Mechanism	Health Care Finance Committee 1994 (HCFC)	Committee of Inquiry 1995 (COI)	SHI Working Group 1997
Primary purpose	advisory/technical (range of issues)	consultative/political (system-wide reform)	policy development/ technical (specific proposals)
Selection of the members	members picked by Minister/Special Adviser	members picked by Minister/Special Adviser	members picked by Health Financing and Economics Directorate/Deputy Director General
Selection of chair	chair picked by Special Adviser	Special Adviser picked as co-chair (with non-government analyst)	by Deputy Director General
Framing of issues in the terms of reference (TOR)	broad terms of reference	DOH agenda (universal access) made clear but attempt to keep TOR narrow defeated	DOH agenda made clear through TOR (SHI based on public hospitals) and also tasked with re-assessing ‘Deeble type’ components ??
Framing of issues through subsequent interventions	DOH agenda (free PHC, Deeble option) made clear during discussions	none	need to consider SHI within wider social security debates raised, but little impact on committee deliberations
Report publication	original report to Minister alone (and only made public some time after submitted, and after press leaks)	draft report made public for comment and then revised before final release	no official publication of report, but version of report published on the internet
Access to Minister	through Special Adviser only, no direct access	through chairs only, no direct access	through Deputy Director General only, no direct access
Acceptance or Rejection of Findings	free PHC accepted, other findings ignored	free PHC accepted, other recommendations largely ignored except by other analysts (e.g. medical scheme regulation proposals)	accepted at MINMEC but rejected by 1997 ANC Mafikeng conference

The non-government analysts, however, consistently resisted these varying efforts to influence their conclusions. They objected to the requirement that the HCFC report be confidential and then countered the ‘Deeble option’ by technical debate and careful strategies, refusing to endorse it in their final report on the grounds that it was neither politically nor financially feasible. “*The knowledge-brokers were able to bring sanity ... into that debate*” (HCFC member private sector). Then in the COI they were not only successful in broadening their initial terms of reference beyond the ‘Deeble option’ but also used technical arguments

to counter it during the Committee's deliberations (see **Chapter 4**). They then included recommendations on SHI as part of a broader set of proposals on private sector regulation in their final report, even though these were beyond their terms of reference. Finally, in the SHI Working Group, led by the government technicians who established the committee, they once more rejected aspects of the 'Deeble option' and then continued technical analysis of the SHI proposals introduced in the COI report – finally releasing their findings in an unofficial report.

The continuing battle over the 'Deeble option' through these committees may be one factor explaining the failure to develop coherent SHI options that could generate a critical mass of support (see **Chapter 4**). In addition, aspects of all three committees' operations appear to have prevented the analysts from thinking through their strategies. In contrast to the SHI Working Group, both the HCFC and the COI were weakened by significant dis-agreements among members. In the HCFC these were rooted in the pre-1994 debate between those who favoured a NHS and those who favoured a NHI (see **Chapter 4**), whilst there was simply a wide range of actors with very different interests represented on the COI (interview data). At the same time, in each committee different people were tasked with undertaking specific analyses and reporting back to the main committee. Given the time constraints, these analyses were inevitably often rather rushed and limited. Members of the HCFC indicated that as different people worked on different parts of the diverse agenda they could not together "*see the wood for the trees*" (interview data). Similarly, as those involved in the SHI WG often worked at night on different tasks there was limited subsequent interaction amongst the group as whole. Much of the COI analytical work was anyway undertaken through a parallel process involving people outside the main Commission and was primarily directed to offsetting the 'Deeble option'. In each case, therefore, there appears to have been little opportunity and/or attempt to review the broader policy picture and develop clear lines of argument on the basis of the analyses undertaken.

A final important factor influencing the functioning of the committees was the lack of interaction with the former Minister. Although senior advisers reported the committees' deliberations to her, Dr Zuma never met with the committees themselves despite their requests for such interaction. In part a reflection of the nature of special committees, divorced from routine decision-making processes, this lack of interaction also seems likely to have reflected the former Minister's growing dis-trust of the analysts. In any case, it resulted in the lack of political guidance that undermined the functioning of SHI Working Group, for example, as well as preventing the analysts from engaging Dr Zuma in debate about her goals and the possible role of SHI in achieving them. In the end, only those aspects of the committees' recommendations which fitted with Dr Zuma's own policy preferences - specifically free primary care - were taken forward in policy action. Even the MINMEC-approved 1997 proposals fell out of favour following the ANC's Mafikeng conference and were, perhaps, never strongly pushed by the Minister in discussions within the ANC (interview data).

Overall, therefore, whilst free care may have been legitimised through these processes, the failure to develop consensus behind broader health care financing reform can be seen as, at the minimum, a missed opportunity and, at most, a waste of the resources invested in the committees. The analysts' strategic limitations in building support for their proposals was matched by the failure of policy-makers to take full advantage of the technical resources available to them through these committees, and both may have missed the window of opportunity for radical change.

Conclusions:

- *the special committees involved in SHI policy development became the site of disagreement between analysts and policy-makers rather than fora for constructive policy dialogue;*
- *policy-makers' efforts to influence the committees' operations promoted support for some aspects of their policy preferences but also constrained SHI policy development as the degree of control became too 'tight';*
- *the special committees' mode of working itself constrained the development of policy through them.*

8.3.3 The weaknesses of strategies for engaging other actors

Further important elements of the experience of the special committees' were the strategies used to engage actors other than policy-makers and technicians/analysts in SHI policy debates. Table 8.4 outlines the strategies applied over time to the three actors who have had particular influence over these, and the related medical scheme regulation, debates – one internal government actor, the Department of Finance, and two actors outside government, the Trade Unions and the private insurance industry.

Table 8.4: Engaging key actors in formal policy structures					
Actor	Strategy of engagement by committee				Actor position on policy proposals
	Health Care Finance Committee	Committee of Inquiry	SHI Working Group	Medical Schemes Working Group	
Department of Finance	not yet active	representation	consultation	consultation	opposed
Trade Unions	none	consultation	marginal consultation	none	generally unclear, but opposed 1997 proposals
Medical schemes	personal involvement	representation	consultation only through medical schemes regulation process	strategic consultation	broadly supportive
Life assurers	n/a	n/a			opposed

The DOF directly participated in the 1995 COI, making its opposition to various proposals, and particularly to the notion of an earmarked tax, very clear. Yet rather than tackling this opposition head on by caucusing with the DOF or strategising with others to offset their opposition, health technicians and analysts appeared to back away from the DOF after 1995 (interview data). This may partly have resulted from the DOF's perceived arrogance towards other government departments, particularly spending departments (see **Chapter 7**; interview data). Thus one analyst noted, "*There was definitely an incredible arrogance in the DOF and they viewed themselves as a kind of level above other government departments. And people came to them for approval, and they said yea or nay and then the other people went back and did things accordingly*" (interview data), whilst a health official suggested that "*their attitude, the budget cuts, the fact that they were not linked to policy – it really soured the relationships – it said we couldn't trust the DOF*" (interview data). In any event, the SHI Working Group sought to address DOF concerns through further design development and consultation rather than by involving it in the design process (interview data). Unfortunately, however, the DOF continued to oppose these proposals even whilst the proposals also earned the dis-favour of the Trade Unions. In contrast, DOF opposition did not stop the process of

developing the Medical Schemes Bill. The health technical team was not only able to defend its position well in relation to the DOF but also to persuade Dr Zuma of the technical arguments in favour of the proposed regulations. As a result the former Minister gave her personal support to the Bill when it was discussed in Cabinet (interview data). This experience suggests that whilst its power within government policy-making makes the DOF an important actor in all health care financing policy development, strategies of engagement can be developed to offset its influence.

Table 8.4 particularly highlights the failure to include representation from the Trade Unions on any of the special committees, despite their broader political importance and potential role within a 'pro-reform' alliance. In contrast, the private insurance industry, about which the new policy-makers were clearly cautious, was represented on both of the first two committees although excluded from the SHI Working Group. The overall weaknesses of these differing strategies is shown by the failure to develop a broader alliance of pro-reform actors with political influence in support of any one set of SHI proposals. The private insurance industry's support for the various SHI proposals was ultimately not enough to counter the opposition of the other two actors (as well as the former Minister of Health).

The failure actively to engage the Trade Unions in the committees may reflect, on the one hand, the higher level political alliance and contact between them and the new government. From the Minister's perspective there may have been no need, for example, to draw a Union representative into the first advisory committee, the HCFC, because Union views were already known or could be solicited through other channels. At the same time, this lack of engagement appears to have reflected weaknesses in the analysts' political skills and analysis. The COI, for example, was criticised by some for making 'glib' assumptions about how the unions would respond because no one on the committee had detailed knowledge of industrial relations' issues (interview data). In addition, although most proposals reflected some consideration of political acceptability there appears to have been little systematic analysis of stakeholder views and little use of their self-reported opinions. Based more on hypothesis than on dialogue, the stakeholder analyses used in policy development particularly under-estimated the potential for opposition from lower income employees to the 1997 SHI proposals. Yet it was precisely this group that had little to gain from them because they already had access to public hospital services cheaply or free of charge and this objection became a critical component of COSATU's opposition to the proposals (see section 8.2). At the same time, however, other obstacles to engaging the Unions included their own delay in developing a position on SHI (see **Chapter 7**) and, in 1997, the Minister's refusal to take forward the proposals and so enable wider stakeholder dialogue at that time (interview data).

In contrast, the most active and interesting strategies of engagement were applied to the private insurance industry (Table 8.4). Despite the former Minister's publicly-stated concerns about the private sector (see section 8.2), the Representative Association of Medical Schemes was deliberately invited to participate in both the HCFC and the COI. During the HCFC, perhaps rather naively, all members were, however, invited only in their personal capacity rather than as representatives of the group from which they came. In contrast, the COI actively sought representation from key interest groups in an attempt to develop a set of proposals that had wide support – both RAMS and employer bodies were represented on this committee. The involvement of RAMS was seen as particularly important in offsetting the potential opposition of the industry to SHI proposals of benefit to the public sector. Through its direct engagement with the private sector, some suggest that the COI was *“able to present the philosophy in a consultative manner and it won the hearts and minds, as it were, of the [private sector] constituency of the time”* so *“when the documentation came out, ... the medical schemes movement was generally one hundred percent behind it* (committee member, interview data).

Box 8.1: Strategic consultation with the insurance industry in developing the 1998 Medical Schemes Act

Maintaining a 'low profile'

"what we decided on in terms of a process privately was that we would actually engage directly with the industry in, a kind of, not an overt process, but a way of capturing their confidence. We decided that it would be a very low-key process, not a high profile process like the SHI committee which just attracts disaster, I mean you can't keep reporters away, all they want to do is kill your process, and anybody that's scared of an output of that process starts turning the press on you." (health policy analyst, interview data)

Establishing the 'high bid'

The proposals were first tested against some of the key actors in the insurance industry to allow subsequent modification. But, recognising that opposition from the industry was inevitable, the working group presented a first set of proposals for discussion that even it knew to be unrealistic. *"...We discussed the issues and out of that we drafted a set of initial proposals on what would be a first run, first brush with the industry on proposals – and they were harsh and deliberately so...The proposals were a kind of ...high bid"* (health policy analyst, interview data)

Reacting to initial responses

In reacting to the responses to the first proposals, the working group was then able to moderate its initial position without losing sight of its main policy objectives. *"So what we did was to try to reach a middle ground in a whole lot of areas so that they would realise that we're not going to get extreme versions of what we wanted through, was to moderate in useful ways so that we still protected the access and equity issues within the Act..."* (health policy analyst, interview data)

Applying the 'divide and rule' strategy

Throughout the consultation exercise the working group was mindful of the emerging split within the insurance industry, and used that to its advantage in overcoming the vested interests in the industry. *"And we also decided we would select very carefully who we knew would be our friends and our enemies within the private sector, so that when the stuff got debated in public, that there would be key role players that supported from the private sector, so the proposals were not taken as draconian and socialistic, and so on..."* (health policy analyst, interview data)

Sources: health policy analysts, interview data

However, the need for private sector representation in policy development structures is unclear. The successful implementation of the 1998 Medical Schemes Act rested, instead, partly on a process of deliberate but careful consultation with the private insurance industry (see Box 8.1; interview data). Given a relatively free hand by policy-makers because initially seen as relatively unimportant, unlike the SHI committees, the 1997 Medical Schemes Working Group developed an approach that exploited the split within the insurance industry towards its regulatory proposals (interview data). This split, in turn, *"relatively empowers the government to push the Bill through without a voice coming from the industry; or if there is a voice it will be a fragmented and dis-empowered voice .. these differences of opinion neutralise the private sector"* (private sector analyst, interview data).

The long-term results of either approach are uncertain. Some criticise the early willingness to engage with the private sector on the grounds that *"... there was a window of opportunity there in which public sector options could have been implemented effectively ... there were possibilities which are no longer present and I think those have been closed down and private sector options opened up in the [last] five years"* (health policy analyst, interview data). Other suggest that the de-regulation of the insurance industry in the early 1990s created a rapidly-changing market that is simply difficult to control, and within which the insurance industry will develop ways of pursuing the most profitable low risk population groups despite regulation (interview data).

Conclusion: SHI policy development was undermined by the failure to develop a clear strategy for engaging actors with different interests and organisational positions in relation to the DOH, in a way that established a pro-reform alliance that could ensure policy development.

8.4 Failing to engage in public debate

A more general pattern within health care financing policy development dating from the development of the ANC Health Plan (see **Chapters 4 and 7**), was that the largely technical focus of the debates within the various SHI committees meant that policy debate was primarily the preserve of the few with relevant knowledge. Even when SHI proposals were opened to broader debate within the COI, “*what really influenced the process was the internal committee debate, and that was modified to some extent by the direct feedback from the key stakeholders. The public stuff influenced us not one iota .. there was no way that those comments could have really addressed the real issues that were occupying our minds, it was quite a technical debate*” (COI member, interview data).

The complexity of SHI proposals and debate was, thus, seen to preclude broader public debate on them. However, an analyst also commented that “*...the whole policy debate gets elevated to a much higher level when you have all the consultants around, so it makes the kind of technical requirements of the process more demanding... potentially what has happened is that the consultants have made the process more complex than it needed to be for the purposes of getting things done .. I think it has almost led to a belief that some of the technical details can substitute for a political decision being made*” (interview data). For example, there was little attempt to clarify the objectives of the proposals or to spell out their implications for different sub-sections of the population (see sections 8.1-2). Instead, they were broadly presented as beneficial to all because they sought to alleviate the private sector crisis and extend coverage. Although the broader tension between actors over SHI may itself have led the wisdom of broader public debate to be questioned, the Department of Health was commonly criticised in this period for its general failure to consult in policy development (see **Chapter 9**). Yet such debate is important in democratic politics, particularly as the “*easiest thing is to cut back on those who have least power*” (budget analyst, interview data).

Conclusion: the technocratic focus of SHI policy debates may have prevented the broader public debate necessary to establish clear goals as a foundation for detailed policy development.

Annex 8.1: Data sources for analysis of actor positions on N/SHI options

SOURCE	STRENGTH OF DATA SOURCE	LIMITATIONS OF DATA SOURCE
Interest group submissions to: <ul style="list-style-type: none"> ANC on draft ANC Health Plan 	<ul style="list-style-type: none"> are the official standpoints of the interest groups are intended to influence policy development so define what, in broad terms, is acceptable or unacceptable to each interest group are often well-considered and therefore fairly detailed and balanced 	<ul style="list-style-type: none"> not all interest groups are represented are made in a climate of uncertainty where massive change is expected to alter the power relationships between different groups dramatically, so may demonstrate more flexibility and willingness to co-operate than in less fluid times are made in the absence of detailed policies so are a more general response to broad principles than to details of design
<ul style="list-style-type: none"> 1995 Committee of Inquiry 	<ul style="list-style-type: none"> ditto in addition, many more interest groups are represented 	<ul style="list-style-type: none"> are part of the first stage in an official process of 'negotiation' between different interest groups, and so may represent only the 'first bid' (i.e. the true bottom-lines/non-negotiables may be hidden) are made in response to terms of reference that focussed on PHC provision, and therefore do not discuss hospital care union opinions are not well-represented
Interest group views recorded in: <ul style="list-style-type: none"> the media (mainly newspapers in the case of SHI) 	<ul style="list-style-type: none"> are intended to sway public opinion and may therefore be more open about the core issues of concern to the interest group 	<ul style="list-style-type: none"> tend to be more ad hoc and fragmented responses, and sometimes more emotive, and therefore give a less balanced or detailed picture of what are the true bottom-lines/non-negotiables are not in response to one particular policy 'moment', making it difficult to associate positions with specific policy designs insofar as the views of powerful interest groups are usually reported through the press that targets a higher-income, business-oriented and often predominantly white readership, the views of unions are generally not well-represented
<ul style="list-style-type: none"> parliamentary debates 	<ul style="list-style-type: none"> as above 	<ul style="list-style-type: none"> as above, with the additions that they may be highly emotive, involve political point-scoring, and not be founded on any technical analysis, making it very difficult to decipher what are the true positions on technical issues
SAZA project interviews with interest groups	<ul style="list-style-type: none"> are more direct and honest opinions because are anonymous are more detailed and reflective responses because are made with the benefit of hindsight and as contributions to a research project (rather than to a policy 'moment') 	<ul style="list-style-type: none"> as reflect on opinions held in the past, may be biased by more recent developments as are made by individuals, may not represent the official or general views of the interest group to which the interviewee belongs do not represent all interest groups, particularly Trade Unions and employers

SOURCE	STRENGTH OF DATA SOURCE	LIMITATIONS OF DATA SOURCE
Reported views of interest groups: <ul style="list-style-type: none"> analyses by policy analysts 	<ul style="list-style-type: none"> as above, where these analyses were performed on the basis of interviews 	<ul style="list-style-type: none"> where these analyses are hypothesised by analysts through their general experience of interacting with interest groups, or through expectations they may have of interest group motivations, they may be biased
<ul style="list-style-type: none"> opinions of SAZA project interviewees 	<ul style="list-style-type: none"> where interviewees have themselves had to engage with interest groups, give a sense of the unofficial standpoints of these groups and bottom-lines/non-negotiables which may never appear through other sources 	<ul style="list-style-type: none"> may reflect biased interpretations by the interviewees
<ul style="list-style-type: none"> document reviews 		<ul style="list-style-type: none"> where these analyses are hypothesised by analysts through their general experience of interacting with interest groups, or through expectations they may have of interest group motivations, they may be biased

CHAPTER NINE DELIVERING POLICY CHANGE: COMMON EXPERIENCES	139
9.1 Links between policy development and implementation processes	139
9.2 The pitfalls of a speedy, ‘top-down’ approach to implementation	140
9.3 Weak leadership for implementation	143
9.4 Weaknesses in provincial implementation capacity	146

CHAPTER NINE

DELIVERING POLICY CHANGE: COMMON EXPERIENCES

This chapter identifies and analyses the key factors that, in addition to those discussed as shaping policy development in Chapters 7 and 8, influenced policy implementation in all three reform areas of focus. It provides some immediate conclusions that are then linked to the discussion and recommendations of Chapter 10.

9.1 Links between policy development and implementation processes

The health care financing policies that were implemented in the 1994-99 period were the apparently 'simple' policy of removing fees and the more complex policies of resource re-allocation. Both Free Care 2 and the resource allocation policies were developed almost exclusively by civil servants who worked within the routine government structures and processes that also provided a 'natural' channel through which the policies could move to implementation (see **Chapters 4, 7 and 8**). The speedy implementation of a health allocation formula in 1994/5, for example, was possible because it was developed and implemented by the body with the primary responsibility for health budget allocations, the Function Committee. Similarly, although a more gradual evolution, the development and application of the hospital-oriented conditional grants in the fiscal federal era was championed by the Department of Finance and implemented through routine, if new, budgetary processes. Provincial Departments of Health were, however, also able to influence these debates through the 'routine' structure of the PHRC.

In contrast, the various special policy development committees were established outside the basic decision-making structures of government. There was, as a result, a gap between policy development and implementation that itself acted as one barrier to taking forward the recommendations of such bodies. The Health Care Finance Committee, for example, "*was largely marginalised ... They were a secret committee, so nothing was coming out of that and being integrated into what was happening in the [provincial] Strategic Management Teams, it was completely divorced from the [Teams]. So these guys [the Function Committee] were getting together and making provincial decisions, another set of more coherent suggestions were coming out of the Finance Committee*" (health policy analyst, interview data). Similarly, SHI policy "*development took place outside of the power structures*" of government (provincial official, interview data).

The effectiveness of special structures in developing policy that is then implemented, thus, seems to have depended on whether there was a 'policy champion' to take recommendations forward into implementation. Two other examples provide further support for this finding. Although the Hospital Strategy Project developed its recommendations through an intense process of consultation, including clear identification of the key steps for implementation and approval by the health MINMEC, these recommendations were only implemented very slowly and partially. In part, this seems to have been because the Project was undertaken by a team of external contractors, and was neither effectively integrated into DOH structures nor benefited from a clear policy champion within the DOH (interview data). In contrast, the Medical Schemes Working Group was much more clearly incorporated within the DOH than any other special policy development structure. And, when the DOF might have blocked its work, the former Minister

stepped forward to act as its policy champion even at Cabinet level. The speedy implementation of both Free Care policies was similarly possible because, whilst initially developed outside routine structures, they were championed by the former Minister (see **Chapters 4 and 7**).

Conclusions:

- *policy implementation was more likely when policy development structures were closely linked to routine government procedures;*
- *policy champions working within government structures always played a critical role in moving from policy development to implementation.*

9.2 The pitfalls of a speedy, 'top-down' approach to implementation

Table 9.1 summarises the key implementation features of the reforms that moved from policy to implementation in the 1994-99 period. It indicates the general lack of pre-planning that was associated with them and the radical, rather than gradual, approach to implementation adopted. Although some preparatory analysis of the limited impact on revenue generation levels of the second Free Care policy was undertaken (interview data), no policy benefited from formal 'risk analysis' of issues such as the adequacy of available capacity and funding, as well as the potential for resistance and even opposition. In addition, little consideration was given in the policy development phase to practical questions of implementation. For example, no guidelines were prepared to guide provincial Departments of Health in implementing either Free Care policy (see Box 9.1) and reforms were implemented across the country at one time, without phasing or piloting. The general lack of focus on learning through implementation was reflected in the DOH's failure to undertake any evaluation of their impact. It even appeared largely to ignore two evaluations of the first Free Care policy, undertaken by the Health Systems Trust (McCoy 1996) and the HCFC (Health Care Finance Committee 1994) which both noted that inadequate consultation and preparation had caused problems in implementing the first Free Care policy. In this latter failure, the health sector only reflected the general government weaknesses in monitoring and evaluation (Presidential Review Commission 1998).

Table 9.1: Key implementation features of selected health reforms						
Reform	Pre-plan	Risk analysis	Phasing	Piloting	Government evaluation	Consultation
Free care 1	no	no	no	no	no	no
Free care 2	some	no	no	no	no	limited
Health resource allocation formula	no	no	no	no	some?	within public sector, across senior management of provinces
Health conditional grants	n/a	no	no	no	not yet	within public sector, across senior management of provinces

The problems of this speedy, top-down approach to implementation are perhaps best exemplified by the concerns raised in **Chapter 5** about both the design and impact of resource allocation and Free Care (see also **Chapter 7**). The editor of the South Africa Journal of Medicine, thus, commented that the implementation of the first Free Care policy "... provided a spectacular demonstration of how easy it is for a noble idea to turn into a nightmare if all ramifications are not anticipated and provided for" (Ncayiyana 1994: i).

B

The announcement of the free PHC policy in 1996 caught many provincial governments off-guard. Despite a proposed implementation date of 1st April, the Free State provincial DOH first heard of the policy only in March. It rapidly put in place a strategy of consultation and delayed implementation until 15th July to allow preparations to be made. The key steps of this process were:

1. Brainstorming within the provincial DOH.

The first step was to involve all government stakeholders in brainstorming around the implementation task ahead - *"people responsible for drug supply, people responsible for the clinical services by doctors, for the different services rendered by nurses etc. And then each of them formed a small team to look at how they are going to cope with this."*

2. Information Dissemination, Communication and Consensus Building

Then there was a series of meetings with different staff to inform them, to identify the problems for which the provincial DOH did not have solutions and to get their ideas on how to implement the proposals. After the meetings, regional managers were then expected to take the message back to their colleagues within regions. Provincial managers also visited regions and through their discussions with staff picked up on problems that needed to be addressed in the process of implementation - such as that clinic staff felt they would be unable to cope with the expected increased workloads.

3. Developing guidelines

As no official implementation guidelines were provided by the national DOH, the Free State DOH filled the gap through a policy circular (number 61 of 1996) which tried to outline all the basic steps that must be taken in implementation.

4. Communication with the public

Efforts were also taken to inform the public about all the changes that would be made to the system as part of the reform package, including new referral procedures. *"So we had radio advertisements in Afrikaans, English and Sesotho to make sure the public understand what it is and also to try and bring in the whole issue of the referral system...we started to focus on that, right through to the end of July, just to make sure that everybody has the message."*

5. Instigation of parallel reforms

In order to make the free PHC policy work it became evident that there needed to be parallel changes in the mechanisms for accessing the public health system. Many patients in the province obtain their primary care from district surgeons (private practitioners who are paid by the government to provide care to indigent patients). Previously, patients had first to go to the magistrate's office where, for a nominal fee, they would be declared indigent – and only then could they go to the district surgeon's office to obtain care. Under the new system patients no longer had to be declared indigent to access primary care, but did now have to a nurse first before being referred to the doctor/district surgeon.

In addition, PHC-related ambulance/transport services (available through contractors for family planning services, for example) which had previously been paid for by patients now became the financial responsibility of government. Contractors were informed of the necessary changes and new systems had to be put in place.

6. Dealing with actors with opposing interests

The introduction of a nurse referral system with free care carried with it the threat of loss of income for district surgeons who were paid on a fee-for-service basis. It also meant that nurses became a sort of watchdog over the district surgeons, causing friction between the two groups. To offset the tensions these new procedures created, the FS government negotiated with the district surgeons to try and develop agreed and acceptable procedures. It also liaised with the Department of Justice, because the new system of referrals not only removed the gatekeeper role that the magistrate's office had played, but also had personnel implications.

7. Tackling resource needs

Two key resource needs were for drugs and staff.

Whilst every effort was made to supply adequate drugs, key drugs were often not available because of national supply problems. In parallel, the province also sought to address concerns that nurses did not have the skills to prescribe. *"we took the Essential Drug List and within it we created two levels, a range of drugs that the nurse could prescribe initially and a range of drugs where the patients should be stabilised by the doctor before the nurse could continue with the treatment and that was also communicated."*

Employing new staff was a particularly complex process. *"We tried to increase the nursing staff, but the process within the province is that you first have to motivate for posts, then you have to unfreeze posts, then you have to advertise the post, which usually takes up to 6 months and then you have to have interviews for the post. And with the local authorities, fortunately that could be done quicker. But we had to give a commitment in writing that we would fund that post 100% as [the province] hadn't budgeted for it. So we just committed; fortunately we did not overspend in DHS, but we had to say 'please appoint we will give 100% funding for this post', so that we deviated from the subsidy regulations in that regard."*

8. Capacity Development

The Free State implemented a two week course to prepare nurses for their extra diagnosing and prescribing duties, using existing training personnel. Whilst inadequate, at least some training was provided before implementation. In addition, a stress management course was initiated by the provincial mental health department in response to providers' concerns about the increased stress levels resulting both from increased workloads and friction between doctors and nurses.

9. Evaluation to facilitate improved future implementation

Finally, the province conducted evaluations of implementation. *"The first one was just to make sure that the message got across, and we just had a checklist.... Each region had to go to each clinic and identify "Did you receive circular 61? Do you know what the contents are? Is this available?", just a two page checklist to see what was going on... We had other follow-up evaluations to look at clinic structures...There are still evaluations being done on a quarterly basis at the moment which involves a multi-disciplinary team."*

Initial evaluations identified that many doctors had not received the policy circular and that clinics were having problems with provision of curative services. Steps were taken to address the problems. Because the provincial information system had collapsed the evaluations also provided the only information on utilisation increases/decreases at different levels of the system, and confirmed the picture of system stress.

Questioned on the first Free Care policy in 1997, former Minister Zuma recognised that "With hindsight I should have called a big indaba that did not only involve the MECs, but also representatives of the superintendents of hospitals and the nursing staff to discuss the issue". However, she also noted that this "... might not have been possible because by the time you decide to do this and get a tender on who is to organise thus, your 100 days are gone (Interview with Minister Zuma, *The Star* 3rd November 1997). Similarly, the then deputy Director General suggested in 1998 that, in general, "...we could neither afford nor justify inactivity that would attend any preoccupation with the stages of a rational planning process" (Ntsaluba 1998: 5).

However, the experience of implementing the second Free Care policy in the Free State province (see Box 9.1) suggests that a more gradual and yet still speedy process could have been possible. The overall picture is one of intense communication, system development and consensus building. Putting implementation concerns at the heart of policy development allowed potential blocks to implementation to be identified and addressed and so eased the following process of implementation. Even so the timelines still appear to have been too short to achieve all the necessary preparation and the capacity of the system to provide drugs and ensure adequate levels of human resources was stretched during implementation.

Conclusions:

- *speedy, top-down implementation may have taken advantage of windows of opportunity for policy change, but, perhaps unnecessarily, prevented the preparation necessary for effective implementation;*
- *the failure to develop monitoring and evaluation systems reflected the more general failure to learn from past experience that has characterised implementation practice.*

9.3 Weak leadership for implementation

9.3.1 Weaknesses of 'management style'

Strong political leadership appears to have been important in enabling aspects of health care financing policy development (see **Chapter 7**). However, the former Minister of Health's overall management style, what has been called "*the combat mode of progress: advance now and count the casualties later*" (Gevisser 1996: 33), represented a weak approach to policy implementation. It not only provoked opposition from groups that might have been prepared to support particular policy changes, but also undermined the communication and planning that could have eased implementation (see Box 9.2). The approach was also reflected in the management style of the first Director General of Health, who critics suggest got too involved in policy development and so could not adequately guide implementation. For example, "...*why should the DG sit on ... get so involved in the Committee of Inquiry. She should have taken all the strategic output of and made sense of it*" (government official, interview data).

As Table 9.1 shows there were, therefore, only limited consultation, mostly with senior provincial managers, over both resource allocation policy and the Free Care policies. Thus, "*the people who develop policies are not the people that develop budgets ... They do them with very little recognition of the resource implications of the policies. ... Nobody has taken account that the provinces don't have the skills*" (budget analyst, interview data). In relation to the first Free Care policy "... *health workers expressed discontent that they had not been involved in the planning and implementation of the policy. They felt that the policy had been a unilateral decision forced upon them without consultation, without a proper assessment of available resources and capacity and without consideration for the effect that it would have on existing services*" (McCoy 1996). Similar views were also expressed about Free Care 2 (Magongo and Cabral 1996). Lack of consultation was also seen to be a broader public service problem (Presidential Review Commission 1998).

Health sector critics, thus, suggested in 1996 that "...*there should be more substantive process; that complex reforms are often implemented in a scattershot manner, with little consultation and nowhere near an adequate level of planning and research or pilot programming*" (Gevisser 1996: 33). The experience of the Free State (Box 9.1) provides examples of the type of consultation and pre-planning that could have been more widely undertaken.

Box 9.2: Common criticisms of the DOH

- "*Unfortunately, this Ministry is already widely perceived as being arrogant and autocratic even by some of its friends ... Publics from as diverse a background as the pharmaceutical industry, the NPPHCN, the AIDS lobby and doctors' groups all complain that the Ministry does not consult in good faith, and is often difficult to access*" (*South African Medical Journal* 1998: 1).
- "*Zuma's determination to make changes has ended up making her look like a bull in a china shop – because she's just gone and done it and other people have been able to set her up to make her look highly authoritarian*" (social policy observer, interview data).
- "*Professor Dave Morrel of the Wits Medical School believes the content of the ANC health policies is excellent. His criticism of the department was its inability to communicate*" (*The Star*, September 16th 1996)

9.3.2 Poor priority setting

A second aspect of the national Department of Health's weak leadership for implementation was its failure to set priorities for its actions in the 1994-99 period. *"They were totally over-ambitious or unstrategic in the issues that were taken on initially"* when *"they could have chosen six issues to handle in five years, and just hammered in all their resources"* (health policy analysts, interview data).

In addition, the former Minister and the DOH focussed initially on implementing new policies with political value (see **Chapter 7**) rather than implementing some of the less 'politically symbolic' but basic changes required within the health system, and across provinces, as a foundation for further, more substantial change. It appeared that the 'sequencing' necessary to support the implementation of complex reforms such as SHI was apparently simply not recognised. The generally slow progress in tackling hospital management problems, particularly in developing billing systems and revenue retention arrangements, thus, continues to constrain further health financing and system change (see **Chapter 6**).

The underlying causes of such limited action were, partly, the national department's own struggle to come to terms with its own capacity problems, as well as those of provincial departments of health, in the same context of radical change (see section 9.4; **Chapters 3 and 7**):

"The medical schemes have said that in principle they are happy to work with us [in relation to improving billing systems] but there's not been a lot of progress on that. I think it's been partly a lack of, I wouldn't say lack of capacity at national level, but just other priorities at national level" (national health official, interview data);

"It was clear that the few people with extensive technical skills, as well as skills in strategic planning and management, were being stretched to their limits by the demands of health departments. It was also clear that most planners were pre-occupied with the business of managing daily problems and were less concerned with issues of long-term strategy" (Hospital Strategy Project team member, interview data).

The internal functioning of the National Department of Health moreover exacerbated these problems, in that organisational divisions separated technicians working on the same sets of issues. For example, the Directorate of Health Financing and Economics was distanced from the discussions of hospital fees and revenue retention taken forward by the Hospitals Chief Directorate (interview data). Yet it co-ordinated the development of SHI proposals that can only be implemented on the back of improvements in hospital billing systems and revenue retention. One official commented that, *"there certainly have been tensions between chief directorates but by and large people work quite well together when we can get together to discuss problems. The biggest problem is not knowing what another chief directorate is doing and either leaving gaps in work or duplicating work, so, communication about what we are doing is still a problem"* (national health official, interview data).

Some of these problems were, however, addressed over time, particularly as the national DOH team developed skills and experience, and got more used to working together. The chair of the national Portfolio Committee on Health, thus, noted in a parliamentary speech in 1998 that *"... in the years 1994-97 the Department of Health strained under the pressure of dramatic and unprecedented transformation, but stability and sound administration have now been achieved"* (Republic of South Africa 1998: 1561). And in 1999 new organisational structures and working relationships were established within the national department to facilitate greater co-ordination amongst those working on different aspects of the same broad area of policy.

9.3.3 Lack of clarity in governmental roles and responsibilities for implementation

Given the evolving governance structure of the country it is not surprising that the relative roles of national and central levels in policy processes remained unclear (see **Chapters 3 and 7**). Some aspects of health policy development in the 1994-99 period appeared to reflect an understanding that the central level develops policies and the provinces implement them (e.g. Free Care). Even though provincial Departments of Health played an important role in resource allocation policy development in the fiscal federal era this policy was also more strongly influenced by the national Department of Finance – for example, in its preference for the hospital focus of conditional grants (see **Chapter 7**). Yet the differing contexts and needs of each province might suggest that policy development should, in principle, more clearly reflect those differences if it is to enable effective implementation. There is, however, clearly a tension between policy that better reflects provincial needs, and so may have both allocative efficiency and political gains, and the incoherence that might result from provinces developing policy without reference to each other or to national goals. Co-ordination of resource allocation policy through the PHRC in the fiscal federal era suggests that this tension can be managed (interview data), although the pattern of resource re-allocations (see **Chapter 5**) demonstrates some of the potential problems.

There were also clear signs in the early part of the 1994-99 period that the national DOH did not think through its role in supporting provinces to implement policy changes – in pursuit of the ‘co-operative governance’ required by the Constitution. The problems faced by the Free State in implementing free care despite its improved implementation process (Box 9.1), for example, point to the need for national leadership in creating an enabling environment for change. Some actions, such as ensuring adequate drug availability across the country, simply required co-ordination across provinces. Other actions, such as permitting nurses to prescribe, required changes in regulations at the national level. *“It would have been good for the national level to have identified those policy issues and just changed them – changed the regulations, just do something to make it easier for provinces. The support we could get from the national level wasn’t there”* (provincial official, interview data). Even after its role in setting norms, strategic planning and policy co-ordination had become clear, provincial officials still expressed concern that due to poor prioritisation and high workloads it still tended to deal with *“non issues”* (interview data).

A final problem throughout government in the 1994-99 period was the general lack of co-ordination and co-operation between sectors, linked to what the Presidential Review Commission called *“a vacuum at the centre of government”* (1998, section 2.2). However, the establishment of regular meetings among departmental ‘clusters’, such as the social welfare cluster, and a central Cabinet Secretariat, after the 1999 elections seem to provide a foundation for improved coordination within government.

Conclusions:

- *the failure to involve implementers in policy development contributed to the implementation problems resulting from poor policy design;*
- *the failure to build consensus around policies through consultation processes undermined support for the policies and the achievement of policy goals;*
- *implementation was constrained by weak priority-setting by the national DOH in the early days of the new government and, in particular, by the limited focus on changing basic administrative systems (but this may have been inevitable in a system undergoing profound structural change);*
- *lack of clarity in the role that the national level should play in enabling implementation by provinces undermined effective leadership of implementation activities.*

9.4 Weaknesses in provincial implementation capacity

Whilst the term ‘capacity’ is often used to refer only to the availability and skills of personnel, it is used here with the understanding that capacity requires not only human resources but also effective management systems and communication networks, as well as a supportive environment (Brijlal and Gilson 1997; Hilderbrand and Grindle 1994). South African experience in the 1994-99 period demonstrated problems in all these aspects of capacity, problems that both limited the extent of resource re-allocation achieved (see **Chapter 5**) and that may have simply deterred implementation of the basic changes necessary to support implementation – for example, in hospital management systems (see section 9.3).

9.4.1 Contextual constraints

The context of reform implementation in the 1994-99 period was itself a critical obstacle to achieving change (see **Chapters 3 and 7**). In the earliest period, people new to their jobs sought not only to understand the bureaucracy in which they were now based but also to initiate wide-ranging and radical change within the public health system. Even in later years health care delivery continued to occur within a system that was still evolving, as reflected in changes in:

- resource allocation approaches that enhanced uncertainty and influenced levels of resource allocation at provincial level;
- the roles of different levels of the governance system that influenced understanding of where the responsibility for different tasks lies (see section 9.3);
- the macro-economic framework that influenced resource availability for implementation within provinces and, as nationally-determined norms and standards were imposed on provinces, contributed to the problem of ‘unfunded mandates’ at provincial level after 1996 (see also Box 9.3).

Box 9.3: GEAR and the ‘unfunded mandates’ of provinces

Some analysts have suggested that GEAR has exacerbated the financial problems faced by provinces and, in particular, the discrepancy between funding and responsibility – what has become known as the ‘unfunded mandates’ of provinces. In January 1998, for example, the Eastern Cape, one of the most disadvantaged provinces, failed to pay over 600,000 people the pensions due to them - leading to massive media coverage of the impact on the vulnerable elderly, and an eventual central government ‘bail out’ for the province of R800 million. The popular view blamed the province for incompetence and corruption. However, detailed analysis of the Eastern Cape budget (van Zyl 1998) showed that the province actually increased the proportion of its budget allocated to Welfare in the 1997/98 financial year in comparison to the 1996/97 financial year, by 1.7%. The 1998 problem, therefore, appears to have been a carry over from the 1996/97 financial year, the last year in which the national level was still in charge of allocations between provinces for welfare services. The national government failed to allocate sufficient funds in 1997/98 to allow the province to meet the social welfare commitments that the national level had established for it.

In other words although national ministries may have sought to improve social sector provision and inter-provincial resource allocation by setting norms and standards, provinces - particularly relatively under-funded provinces – were not necessarily given the resources they needed to implement these standards. These problems may also have only exacerbated provincial capacity weaknesses in the poorer provinces (May 1998; van Zyl 1998).

In this context a major achievement was simply the “*re-integration of government, following the country’s balkanisation under the apartheid system*” (Presidential Review Commission 1998: section 2.1.3). For example, in the health sector, “... *a trustworthy Department of Health [was created] in the centre and in the provinces in very short order. As achievements go that’s an awesome achievement*” (health policy analyst, interview data). Indeed, the national Departments of Health and Agriculture were singled out for commendation by the 1998 Presidential Review Commission for achieving a “*better balance between service delivery and internal transformation than other departments*” (Presidential Review Commission 1998, section 2.5).

9.5.2 Continuing centralisation and weak administrative systems

An important factor that influenced implementation practices in the 1994-99 period was the continuing imbalance of powers between central and lower levels of the administrative and governance system. Structural reforms pointed to the intent to decentralise government authority from the national level to lower levels. The very creation of provinces with constitutionally defined powers was the fundamental act, together with the legitimacy given to local government. In the health system, this was complemented by the emphasis given to establishing a District Health System as the central element of re-structuring within the public health system (Department of Health/Health Policy Co-ordinating Unit 1995), whilst the 1997 White Paper on the Transformation of the Health System indicated the intent to decentralise hospital management. However, the experience of health managers at provincial and lower levels demonstrated the continuing centralisation of authority within the bureaucracy and, in some cases, even a growth in centralisation at specific levels of the system.

The experience of seeking to manage resources at provincial level, both to improve equity and efficiency, provides an example of the uncertainty and frustration of working within the evolving administrative system. First, following the implementation of the 1995 Labour Relations Act collective bargaining agreements governed public service personnel decision-making. Such agreements were seen by some as having the potential to promote changes in the ethos of public service delivery or efficiency gains within the public service (Heintz 1999). However, they were perceived by provincial Departments of Health simply to have undermined their management authority. All decisions on grades and pay levels for public health workers were taken within the Public Service Coordinating Bargaining Council where representation of the health sector is limited and, indeed, where there was no representation from the provincial health departments. By, in effect, removing control of personnel expenditures from their hands, this body also dramatically reduced the ability of these departments to manage their own resources given that personnel expenditures represent the dominant expenditure in all provincial health budgets (see **Chapters 3 and 5**; interview data). Second, the capacity of the PDOHs to manage resources was also sometimes undermined at provincial level by the relationship between the department and the Provincial Treasury. In the Eastern Cape, for example, financial management difficulties across the province as a whole led its Treasury to take to itself much of the financial management power previously lying with sectoral departments. Although seen by some as a result of decentralising too much authority too soon to a particularly weak province (Presidential Review Commission 1998), the message given by this sort of action was confusing to, for example, provincial health managers and undermined their authority to manage. As an official of another province commented, the PDOH was really only an administrative unit with real power lying elsewhere in the province (interview data).

Box 9.4: Continuing problems of hospital and district health management in South Africa

- highly centralised administrative systems give managers inadequate authority to manage their institutions
- budgeting and personnel management systems reinforce lack of authority of hospital management by, for example, preventing transfer of budgets between line items
- financial and personnel management systems do not produce the information required to manage resources effectively
- key management functions such as procurement, maintenance and transport, are located outside the health sector and are the responsibility of other government departments
- cumbersome and time-consuming tendering systems
- hospital and provincial managers not held accountable for financial management performance

Sources: Brijlal *et al.* 1997; Monitor Company *et al.* 1996

The impact of these two factors on resource management were themselves also exacerbated by the centralisation in, and weaknesses of, basic administrative systems and procedures that was part of the apartheid legacy (see also Box 9.4). Apartheid management practice was “*closed, hierarchical and unaccountable to the community*” (Centre for the Study of Health Policy 1989: 9), and suffered from the deficiencies characteristic of many bureaucracies in developing countries, such as rule-driven bureaucracy, outdated management practice, unresponsiveness to consumers, lack of accountability and transparency. Thus, “*An examination of existing public institutions reveals that current systems and structures are an inappropriate administrative apparatus through which to implement developmental policy*” (Swilling and Woolridge 1996: 156; see also **Chapter 3**).

A specific aspect of these problems relevant to financing issues was that planning and budgeting processes were divorced from each other and budgets continue to be developed at least partially on the basis of historical budget patterns (Brijlal *et al.* 1997). In addition, financial and personnel management systems simply do not generate the information required to manage resources - for example, they do not link costs and outputs meaningfully (Brijlal *et al.* 1997; Monitor Company *et al.* 1996; Presidential Review Commission 1998). These problems not only constrained initial policy development (see **Chapters 5 and 7**), but also continue to undermine all health planning activities. A manager in the national department of health explained some of the consequences:

“I remember one head of a provincial health department saying that he was told one week that he had grossly overspent - this was a month before the end of the financial year - and that he must really cut back, and two weeks later he was told, actually, he had unspent funds. So he was saying, if the financial management system of the province ... was giving him such different information, how the hell could he manage. Because he gets one message and starts freezing posts ... anything to save money, and then two weeks later he’s told, ‘you’ve got unspent money’ and he looks like a fool” (interview data).

Problems tend to continue to be greatest in the provinces that were disadvantaged by apartheid in terms of resources and that, after the 1994 elections, were faced with amalgamating the bureaucracies of former homelands and provinces (Presidential Review Commission 1998).

Efforts taken to address these problems include the introduction of the MTEF process. This was broadly welcomed as improving transparency, allowing wider debate on budget matters and bringing more stability to budget decisions (interview data). The Presidential Review Commission (1998), for example, suggested that it:

- permits policy development to be linked with resources over time;
- creates a predictable medium term planning environment;
- provides a framework for assessing priorities;
- promotes the credibility of the fiscal strategy by, among other things, making explicit the assumptions on which projections and prioritisation are based.

In 1999 there were two other important developments for administrative practice. First, a separate Health Sector Bargaining Chamber was established that will allow health issues to be dealt with separately from those of other civil servants and that will give PDOHs a stronger role in salary matters. Second, the Public Financial Management Act of 1999 also provides the basis for harmonising financial management issues across the civil service and for developing stronger accounting practices.

However, even if these developments strengthen provincial management possibilities they do not tackle all of the problems of financial management. For example, planning for capital spending remains weak – with capital budgets allocated totally to the first year of any project even though it may take several years, particularly given delays in the tendering process, to complete (interview data). The 1999 financial management regulations also still do not allow for revenue retention, seen as an important element of strengthening hospital management (Monitor Company *et al.* 1996), although some provincial ‘experiments’ have been initiated to explore ways of retaining revenue within existing regulations. At the same time, the weaknesses of information systems continue to undermine planning within the health sector, and government more generally (Presidential Review Commission 1998). The experience of the MTEF implementation in the health sector, with limited information and short deadlines, finally re-emphasises the importance of process to effective implementation. As one provincial official commented on the MTEF, “*it’s a sophisticated idea that we give to people who don’t understand it yet*” (interview data).

9.5.2 Human resource problems

The current weaknesses of hospital billing practices illustrate how the problems of centralised and weak administrative systems are only compounded by poor human capacity - that is, poorly motivated staff with inadequate skills (see Box 9.5).

Box 9.5: Hospital billing systems, a case study of poor administration systems

Problem: low proportion of potential revenue collected

Causes:

- information systems inadequate to handle large volumes of patients and complex billing systems
- lack of appropriately trained & motivated administrative staff
- extensive mis-classification of patients due to lack of administrative knowledge, fraud and patient dishonesty
- failure to identify all treatments/services provided due to poor information systems, & poor communication between clinical and administrative staff
- poor communication & relationships with organised payers such as medical schemes, Motor Vehicle Accident fund, Workmens’ Compensation Commission and other government departments
- severe mis-management of bad debts due to administrative incompetence and regulatory restrictions
- complex billing systems due to administrative and regulatory requirements

Sources: Monitor Company *et al.* 1996; van den Heever and Brijlal 1997; Working Group on N/SHI 1997

The skills' weaknesses of the administrative and clerical staff responsible for billing practices are only reflected at higher levels of management. As noted, the centralised nature of the public service system in the apartheid era led to the systematic underdevelopment of management skills at all levels (Monitor Company *et al.* 1996; Presidential Review Commission 1998). In the health sector this was exacerbated by the general under-development of health service management as a discipline (Centre for the Study of Health Policy 1989). Career paths, remuneration and job satisfaction have also all been identified as undermining the public sector's potential to attract and retain skilled managers (Monitor Company *et al.* 1996; Presidential Review Commission 1998). The skilled staff available are, moreover, unequally distributed within the system, with the richer and more urban provinces, and areas of provinces, better able to recruit and retain staff than the more rural/poorer areas (Brijlal *et al.* 1997; interview data). Nonetheless, provincial officials in the Western Cape also noted that it had a high vacancy rate for planning posts and had lost large numbers of staff since 1994 (interview data). The voluntary severance package (VSP) agreement reached with public service unions in 1996 allowed some of those with skills to leave the public sector with handsome payouts and the 'sunset clause', agreed at the time of the constitutional negotiations, forced the government *"to carry many senior civil servants who were anxious, demotivated and, in some cases, hostile"* (Presidential Review Commission 1998, section 2.1.3; see also **Chapters 3 and 5**).

The diversity, speed and manner in which changes to systems were implemented in the 1994-99 period again, only exacerbated these problems. The experience of implementing the Free Care policies amply illustrates the problem, whilst one provincial manager said, *"I find it difficult to implement all the things and I'm fairly skilled .. to expect this from [untrained staff] is unfair. We're making them frustrated, we keep on giving them more and we hammer them if they don't give it. It's just plainly too much"* (interview data).

Conclusions:

- *a good foundation for implementation was established through the general transformation of health sector structures, but the need for this transformation itself constrained other actions required to support implementation at provincial level;*
- *the very weak capacity for implementation within provinces itself undermined the practice of policy implementation;*
- *the failure to decentralise adequate authority was a critical element of the weakness of implementation capacity at provincial level.*

CHAPTER TEN RECOGNISING THE DYNAMICS OF POLICY CHANGE	151
10.1 Overview of experience: health care financing policy change in South Africa, 1994-99	151
10.2 Strengthening policy formulation as a foundation for implementation	153
10.3 Strengthening implementation directly	161
10.4 Strengthening policy design	164
10.5 Towards ‘delivery’: strengthening the policy process	174
Annex 10.1: Overview of the pattern of health financing policy achievements, and explanatory factors, 1994-1999	181
Annex 10.2: Strengthening the processes of health care financing development and implementation in South Africa (with specific reference to SHI and Norms and Standards)	184
Annex 10.3: Summary of international experience concerning the ways in which SHI may have positive and negative impacts on equity, efficiency and sustainability	188
Annex 10.4: Designing mechanisms for improved cross-subsidisation from private to public sectors in South Africa	190
REFERENCES	193
ADDITIONAL BIBLIOGRAPHY	206

CHAPTER TEN

RECOGNISING THE DYNAMICS OF POLICY CHANGE

10.1 Overview of experience: health care financing policy change in South Africa, 1994-99

The first democratically elected South African government, led by the ANC, initiated wide-ranging and radical change in the health sector over its first term in order to tackle the apartheid legacy of inequity and inefficiency in health care delivery, financing and administration. In a review of health policy development by 1998, the then Deputy Director General in the national Department of Health, thus, commented that: “(w)e... have made significant strides in formulating policy, passing necessary legislation and broad programming. For us this was very important, as we had inherited a plethora of legislative and policy frameworks, which were inappropriate and contradictory to our new direction” (Ntsaluba 1998: 5). Changes in health care financing policy were elements of the wider array of health reforms and contributed in important ways to the impressively speedy re-orientation of public service provision to better meet the needs of the majority of the population.

In considering the pattern of reform development, however, the then Deputy Director General also reflected the particular experience of health care financing change in suggesting that, “A critical review of our health reform process over the last four years indicates an uneven pattern of incremental progress towards our desired objectives” (Ntsaluba 1998: 10).

As the management of health policy reform is always difficult, and particularly within a context of broader social transformation, the achievements of the first five years of office are in some ways remarkable. Nonetheless, it is, in effect, the ‘unevenness’ of health care financing change over the 1994-99 period, and the difficulty of translating policy change into service delivery change, that this study has identified as problems. The financing changes achieved in this period were tempered by problems both with individual reforms and by gaps in the overall package of financing reform. The short-term gains that resulted from aspects of financing policy change may, therefore, represent only a weak foundation for the longer-term changes need to address the complex health system problems inherited from the past (see **Chapter 3**).

The analysis of this study identifies three key financing areas in which policy change was achieved over the 1994-99 period. Each has achieved, or has the potential to achieve, equity and sustainability gains. They are:

- the speedy implementation of the two free care policies, with subsequent gains in terms of improved financial access for specific vulnerable groups;
- the speedy implementation of a health sector resource allocation formula that supported geographic reallocations of budgets in favour of the formerly under-resourced provinces;
- the passing of the 1998 Medical Schemes Act which has the potential to tackle critical problems within the private insurance industry, such as cost inflation and risk selection, and so to have positive equity and sustainability impacts.

However, these successful policy actions also appear to have had weaknesses. Although the available data are limited, the two free care policies seem to have had a negative impact on aspects of sustainability (through utilisation increases and lower provider morale, respectively, see **Chapter 5**). They also shaped the nature of subsequent SHI proposals by appearing, at least, to remove the potential for a combined primary-plus-hospital care benefit

package. The subsequent focus on a hospital package within SHI policy proposals not only contributed to the political unpopularity of these proposals, but also limited their potential to generate allocative efficiency gains (see **Chapters 6 and 8**). In parallel to the free care reforms, resource re-allocation in the health sector occurred so quickly that provinces were neither able to absorb budget losses or gains effectively. As a result, the real resource reallocations across provinces promoted by the policy were less than the budgetary reallocations and there was only a limited degree of reallocation between levels of care (see **Chapter 5**). This weakness, in turn, reflects a problem with the overall health reform package – that is, the limited attention given to developing the public sector ‘organisational capacity’ necessary to implement any financing (or other health system) change effectively (see **Chapter 7**).

The initial successes in financial resource reallocations also appear to be under threat since the implementation of the unconditional block grant budget allocation process. By 1999 limited progress had been made in developing procedures for influencing health resource allocations between provinces. These problems were compounded by the equally limited progress made in tackling intra-province inequities in health resource allocations (see **Chapter 5**). Together the lack of action on these resource allocation issues represents one of three important gaps in health financing policy development over the 1994-99 period.

The second financing policy gap was the lack of attention given to public hospital funding issues, including very slow progress in simply agreeing a uniform fee schedule across provinces. As hospitals consume the vast majority of the public health sector’s resources (81% in 1992/93: McIntyre *et al.* 1995), tackling their funding and related management problems is central to change within the public health system as a whole.

The third policy gap of the 1994-99 period was the lack of a comprehensive financing reform, such as N/SHI, that touches not only on the public health system, but also, for South Africa, the critically important private health sector (see **Chapter 6**). The failure to implement such a complex reform in only five years was inevitable and debates thus far may have been useful in clarifying the critical political and technical issues that must be considered in developing such a reform. However, the limited progress in even developing a proposal that had adequate support to move towards implementation, although the first N/SHI proposals dates from before 1994, was disappointing. Lessons of the past need to be drawn into future policy development in this area. Most importantly, the 1998 Medical Schemes Act simply cannot by itself address the fundamental equity and sustainability problems that the South African health system faces due to the resource mal-distribution between public and private health care sectors relative to the populations they serve.

In explaining the overall picture of health care financing policy development in the 1994-99 period, **Chapter 5**, first, outlined the issues of policy design that help to explain the mixed equity and sustainability impacts of those reforms that were implemented in the period. **Chapter 6** then explored the potential role of SHI in tackling the remaining equity and sustainability problems of the health system with specific reference to the design issues that must be considered in future policy development. **Chapters 7-9**, finally, identified the complex web of factors that further explain the nature and pattern of health financing policy change across all reform areas of focus over this period. Annex 10.1 provides a summary of the overall group of factors that underlay each of the health care financing achievements, weaknesses or gaps identified above.

These analyses point to specific policy design weaknesses that need to be addressed in future policy development. Equally importantly, however, the study emphasises that in developing and implementing policy on specific financing issues it will be important to strengthen the

management of the whole reform process – from policy formulation to implementation. Then, drawing on the conclusions identified in Chapters 4-9, the following sections provide further ideas about how to strengthen future health care financing policy development. Although largely derived from consideration of the national and cross-provincial policy reform processes of the 1994-99 period these recommendations have relevance for both the provincial and national health managers that jointly have responsibility for maintaining the momentum of health system development. Finally, although these recommendations are directed first at a South African audience, they also seek to address the international health policy community. Despite the inevitable differences between countries, policy development in any one setting can be enhanced by considering both what is relevant and what is not relevant in the lessons derived from another country's experience.

10.2 Strengthening policy formulation as a foundation for implementation

This section provides broad recommendations about how to strengthen the process of policy formulation as a critical basis for the effective implementation of policy change. They are drawn from, and closely linked to, the conclusions presented in **Chapters 7-9**. More specific, related recommendations for South Africa, focusing particularly on the development of proposals for SHI and norms and standards, are presented in Annex 10.2.

10.2.1 Supporting leadership with technical analysis

Strong political leadership was important in initiating wide-ranging policy change in South Africa between 1994-99, particularly in a context of rapid structural change and given the strength of vested interests in the health sector. In addition, the personal influence of the former Minister of Health may have ensured action that was sensitive to the political needs of the moment. However, the limited availability and use of information and technical analysis for policy development undermined both priority setting and design development in relation to health care financing policy.

Information and analysis are particularly important as societal objectives such as equity and sustainability may be undermined by what at first appear to be politically attractive policies, such as free care or unconditional provincial block grants. More open processes of decision-making, that is processes involving more actors and so allowing more views to be heard, may also help to ensure that relevant information is available to decision makers at the right time, even though they may slow down policy development. At the very least, there needs to be closer coordination between policy makers and those groups inside or outside government that can provide necessary analyses – particularly at short notice.

1. Strengthening health economics capacity within government

Limited health economics 'capacity' in South Africa, and particularly in government, was a factor peculiar to the arena of health care financing reform that led to the design weaknesses of financing policy in the 1994-99 period. On the one hand, health economists were initially seen only as budget managers; on the other hand, health financing reforms were not developed with clear recognition of their links to other, parallel reforms. The capacity problem was not simply a shortage of people with technical skills. A broader failure to incorporate health economics analysis into policy development was also important, leading to the sub-optimal use of the available health economists. In turn, this may have stemmed from policy makers' limited familiarity with the importance and use of health economics in reform processes as well as from the lowly organisational position of the DOH Directorate of Health Financing and Economics. In other words, as is common in other countries, neither the demand for, nor the supply of, health economics analysis is, as yet, adequately developed within South Africa (Paul 1995). However, the process of developing the 1998 Medical

Schemes Act suggests that the combined efforts of policy-makers and technicians can be a powerful force, and that skills and knowledge are developed in material ways through experience, rather than formal training only.

In developing health economics' capacity in South Africa attention particular needs to be given to the needs of the provinces as well as the national level, and to strengthening the relationship between economists and policy-makers. In this regard it will be important to review the influence of the current organisational location of the national DHFE over its effectiveness.

2. Working with non-government analysts

One strategy used to tackle the weakness of health economics capacity in South Africa was to create links between the health economists working inside government, and those supportive of government but based outside it. The nature of these links ranged from no involvement (resource allocation decision-making under fiscal federalism) to participation in internal government policy formulation processes (the Function Committee/Medical Schemes Working Group). In addition, external analysts both led specific policy processes and provided informational inputs to them. Sometimes non-government analysts were given a relatively free-ranging role in policy development (Medical Schemes Working Group), and sometimes policy makers apparently tried to shape or guide their recommendations (Health Care Finance Committee/Committee of Inquiry).

These differing experiences suggest that the role of the analysts in these processes was determined in a rather ad hoc way. This was probably a consequence of the limited experience of the new health policy-makers who were working under immense pressure, and of the nature of the health financing community (small and closely connected across organisational divisions). The resulting lack of clarity around the role of the analysts and the associated differences in expectations seemed to be important explanations of the disagreements between policy-makers and analysts in relation to N/SHI. In contrast, the alignment of government technicians, external analysts and policy makers in developing the 1998 Medical Schemes Act may have reflected a clear division of roles and alignment of interests. It also seems to have been important in ensuring the Act's implementation.

Overall, therefore, whilst there can be value in drawing on external analysts to support policy development, the objectives of their involvement need to be thought through at the outset. These might include the provision of technical information, adding credibility to a process or co-option into policy development. Clarifying objectives then allows the role of the analysts to be defined. This could occur before approaching them – as in terms of reference for contracted or commissioned research - leaving them to decide whether or not to be come involved. Or it might be a result of dialogue with them – as partially occurred in the early stages of both the Health Care Finance Committee and Committee of Inquiry. Agendas were clarified and technical input guaranteed only on specific conditions. In contrast, the lack of clarity on the role of the 1997 SHI Working Group only led to frustration and lack of action. Where analysts are being brought in to support a particular line of thinking this may need to be discussed with them in advance. Although there may be strategic gains in getting 'impartial advisers' to support a particular policy, they may react negatively to efforts to influence their views (as also occurred in the Health Care Finance Committee and Committee of Inquiry).

Analysts also need to think through the terms on which they are prepared to be closely involved in policy processes, and the circumstances under which they might prefer to remain outside them or disengage from them. The potential alignment or conflict between their

opinions and those of the policy makers is likely to be important in this decision, as well as the need to retain their independence and perceived objectivity.

However, given the small pool of health economists (and even other public health specialists) in most low and middle income countries some form of collaboration between government technicians and supportive external analysts is likely both to be required and to be valuable. A foundation for mutually acceptable collaboration may include discussion of topics where collaboration may be possible, as well as clarification of the different roles that the two groups may play in different policy debates.

10.2.2 Developing the strategic skills and tactical awareness of technicians

The experience of developing financing reforms in South Africa over the 1994-99 period indicates that technicians and analysts often have to do more than 'simple' analysis to make an effective contribution to the policy process. For example, their aim may be to get dominant actors to see the 'problem' as they see it, even whilst neutralising the arguments of those who oppose their viewpoint. The manner of developing the 1998 Medical Schemes Act by a small group of technical experts shows what can be achieved in the face of potentially stiff opposition from powerful opposing groups.

It is particularly important for those pursuing any reform to understand the relative power and values of the major interested groups. This is the first step in considering how to influence policy development. Also important is to understand how policy design can influence support and opposition for reforms. Reformers might then attempt to persuade such groups to accept their views partly through tailoring information and recommendations to match their interests. Also by publishing results widely in popular media and influential (academic) journals, making specific presentations to top policy makers, trying to lobby individual policy champions among top policy makers and even mobilising third parties with known access to top leaders to get them to support certain positions. To neutralise conflicting groups it may be prudent to try and undermine their arguments (as occurred within the Committee of Inquiry around the 'Deeble option'), while also trying to limit their access to, or effectiveness in, policy processes. Box 10.1 summarises a range of informal and formal strategies that might be used in managing conflicting interest groups. Which strategies are appropriate, and when they should be used, will depend on the stage of policy development, the character of policy opponents and the broader ethos of policy-making.

A variety of techniques, as used in this study, are available to support the development of such strategies and have been identified as important components of the 'tool box' that should be available to senior South African civil servants (Friedman 1998). They include:

- 'stakeholder analysis' – to identify key actors likely to support or oppose a particular policy action, their individual interests and concerns, and the nature and source of their influence (Crosby 1997);
- 'policy characteristics analysis' – to identify the features of any policy that are likely to cause opposition or garner support (Gustafson and Ingle 1992);
- a computer programme called 'Policymaker' which includes a variety of individual techniques (Glassman *et al.* 1999).

Non-government analysts seeking to influence policy development may also use such approaches but they must consider the potential costs to themselves of unashamed strategic action. They may gain influence through such action, but may also lose their perceived objectivity. Such analysts must be clear as to whether they want broadly to inform the policy process or to steer it toward a specific conclusion. The danger of being prescriptive or being always seen to be prescriptive is the possible loss of confidence in the 'integrity' of analysis.

Box 10.1: Nineteen strategies for working with actors

1. Create Common Ground¹:
 - seek common ground with other organisations, identify common interests, link different interests – invent new options, make decisions for opponents easier.
2. Create a Common Vision¹:
 - keeping in mind that the principal obstacles to reform are not only technical: create an atmosphere of shared values, unified leadership, articulate a common vision of equity and the respective roles of the public and private sectors
3. Define the Decision Making Process (around a particular reform)¹:
 - formalise who does what in making a decision and who approves what type of decision, legalise formal processes if relevant
4. Mobilize and Prepare Key Actors for their Roles in Reforms Debates¹:
 - identify who can take leadership positions and provide them with appropriate information, who can influence support/opposition by taking a strong and clear position and provide them with appropriate information, the most critical issues for discussion and focus debate on them.
5. Meet with Political Parties¹:
 - meet with politicians and their technical staff, attempt to integrate health reform policies and specific policy ideas into political debate and discourse, identify their specific concerns on reforms and seek to offset them through technical argument and debate
6. Initiate Strategic Communications¹:
 - initiate strategic contacts with the press, respond to attacks on reforms immediately, feed information and technical findings to the press, place key decision-makers in the media
7. Initiate Pilot Studies¹:
 - select pilot study sites according to technical and political exigencies, focus pilot study work on issues critical to technical understanding and/or political support, preserve neutrality of those involved in pilot study to maintain integrity of findings
8. Manage the Bureaucracy¹:
 - involve different groups in designing reforms, and in developing implementation strategies
9. Strengthen Alliances with International Organisations¹:
 - request technical-political assistance from international financial institutions and other donors in order to respond to criticisms of reforms, work together with supportive donors in some areas, ask for donor support for vision of reform and define their active participation in influencing key actors in the health sector
10. Involve 'Friends' in Planning¹:
 - hold informal consultations with 'friends' of the reform on the sequencing of actions and political strategy, bring together key 'friends' to formulate specific agendas in some reform areas
11. Create Strategic Alliances¹:
 - create alliances with key actors not usually involved in health sector policy debate (e.g. unions, NGOs etc)
12. Use Backdoor Channels²:
 - by-pass formal procedures and meet with those in power to try and influence the development of reforms and/or gain useful information about the future course of events for use in their own activities.
13. Establish Independent Commission of Inquiry To Create Support²:
 - identify relevant 'experts' whose opinions and views will be valued publicly to sit on Commission, establish balance between declared supporters and opponents of reform in Commission membership to maintain neutrality and independence of Commission, provide technical support to Commission to gather additional ideas and/or generate additional analysis, create link between Commission and 'policy champion' within government
14. Establish Independent Commission of Inquiry To Block Opposition²:

- establish balance between declared opponents and supporters of reform in Commission, delay consideration of Commission report/findings after publication until no longer newsworthy
15. Establish Parallel Processes During Formal Commissions²:
- use informal parallel processes to gain guidance from constituencies on positions to take in debates, and/or to generate information to feed into debates
16. Use Technical Information to Offset Opposition²:
- identify key arguments of opponents to reform, undertake technical analysis to offset their arguments
 - use technical analysis to support alternative line of policy development, feed technical analysis into relevant decision-making processes, make technical analysis widely available to policy-makers, media etc.
17. Divide and Rule²:
- put 'high bid' policy document forward for debate, through reactions to 'high bid' document, identify lukewarm opponents and hard core opponents, isolate hard core opponents by developing detailed policy design that offsets the concerns of lukewarm opponents, proceed with policy implementation with support of previously lukewarm opponents
18. Mobilising a Third Party²:
- seek to bring a potentially powerful but as yet unmotivated actor into the debates to support own position
19. Create Tailored Information for the Public and Policy Leaders (TIPPLE)²:
- tailor policy information to different target audiences to seek their support and to influence their understanding

Sources: (1) Glassman *et al.*

1994-1999

analysis or action. The most important, first step, however, is simply to recognise the develop relevant skills or might instead seek to work with others who have the necessary

1. Actively addressing the values of policy elites

makers in relation to the ideas and proposals they seek to put forward. South African technical design of a policy matched these values, and the broader political goals with which necessary pre-condition for further policy development. Both free care policies and the initial national Minister of Health and her senior civil servants. Their support of these policies was improved equity in access to, and financing of, health care. In contrast, the stalemate reached and technicians and the objectives of the national Minister of Health at the time. Working analysts were not successful in tackling her concerns in ways that created a mutually agreed sectors and countries (Gilson 1997b). As Grindle and Thomas (1991: 32) note: *play major roles in the process of policy and organisational change. Because of this the the perceptions of what problems need to be addressed through public sector action and how*

Government technicians and other analysts must, therefore, seek not only to understand the

indicated that engaging the Trade Unions more actively in SHI policy development in South Africa could have also addressed some of the former Minister's concerns on this policy, and so provided the basis for a pro-reform alliance of critical actors.

Third, the mode of engagement may depend on the positive and negative features that an actor brings to the policy process. This may be particularly important where the reformer lacks certain attributes. For example, the DOF has significant power above and beyond that of the national DOH while academic analysts have technical ability in health economics that is in short supply in the DOH. Both attributes are important for developing and implementing policy. It may, therefore, be important to engage with both actors in order to bring their characteristics into the policy development process. The precise mode of engagement may, nonetheless, depend on the 'negative' characteristics of each actor. Can the actor derail the reform? Do they have an agenda that does not match the main goals of the reform? Where either possibility exists the reformer must analyse how to minimise the risk' whilst capturing the actor's positive attributes. For example, the arm's length approach to the private insurance industry during the development of the 1998 Medical Schemes Act drew on its knowledge without allowing it control over the design itself.

Fourth, it is important for government technicians to think through the use of special processes, such as commissions of inquiry, in policy development. They may be particularly useful in specific circumstances and for specific tasks, including when:

- the reform of focus is not part of government's routine administrative tasks and duties;
- government's own technical capacity is insufficient to tackle the reform of focus;
- developing a broader range of options may be useful in bringing new insight to old problems;
- interest group representation and buy-in is important for the reform's credibility and success;
- government needs to be seen to be consulting with other groups.

Alternatively, routine policy processes might be pursued when government has internal capacity and/or issues are less contentious. Such processes may, therefore, be aimed at getting technical advice and/or the strategic engagement of actors. Clarifying the primary objective of the exercise will obviously be important in further developing its mode of operations in ways that support it in fulfilling that objective. Confusion about the primary purpose of the South African special policy processes, thus, led to patterns of working that did not allow them to be particularly effective in undertaking either technical analysis or strategic action.

Finally, the role of formal mechanisms for engaging actors must be considered in relation to more informal strategies. For example, when groups are both powerful and in opposition to the basic rationale of the reforms, their presence on special policy processes or on high-level decision making fora may be counter-productive. To give such groups drafting rights to policy may be to confer on them too much power, allowing them to shape or even block reform implementation. At the same time, to ignore or over-look groups with interest and influence in any policy debate is to invite failure. Instead, directed and controlled information exchange plus negotiation with powerful groups may allow some control of their agendas and contain their influence. The calls for submissions into the ANC's National Health Plan and the Government's White Paper on the Transformation of the Health System, for example, were important catalysts of cohesion. More clearly, the Medical Scheme Working Group managed to push forward policy in the face of opposition from some quarters of the private sector as well as the Department of Finance. Channeled input from opposing parties may lessen the chance of outright hostilities.

3. Improving the communication of complex policy design

The perceived complexity of the policies developed in South Africa over the 1994-99 period appeared to affect whether or not they were developed and implemented. Relatively 'simple' policies, such as free health care, were pursued, while the more complex policy actions of SHI and the development of norms and standards, were not. Often technical complexity seems to have resulted in a breakdown in communication between technicians/analysts and policy makers. International experience clearly suggests that analysts need to improve the language of their own reports, adapting it to the perspective of policy-makers (Trostle *et al.* 1999; Walt 1994). A policy that cannot be expressed both simply and clearly will be difficult to sell. Careful thought about the words used in describing a policy may even help to gain support for it (Parsons 1995). In South Africa, former Minister Zuma, for example, seemed to capture support for some of her policies by the use of 'symbolic language'.

Presenting policies clearly and simply is also important in promoting the public debate about societal goals, and their pursuit through health care systems, that is itself an important part of the democratic process. As reforms evolve they also have to respond to different sets of concerns. Initially, it may be important for technicians and analysts to dwell on the major thrust of policies, ignoring the details, and using non-technical and popular language to justify them in terms of meeting health sector needs and matching the political agenda. Then their feasibility against technical criteria and actor agendas must be presented. Following popular debate and political buy-in, the detail of policy and appropriate methods of implementation are legitimate areas for presentation and debate. Thinking through what information to present when is an important strategy in developing reform.

10.2.3 Building implementation concerns into design development

South African health care financing experience over the 1994-99 period includes both the implementation of policy changes that had negative impacts due, in part, to design problems and the failure to implement policy proposals that had been much debated. Both sets of experiences reflect on the failure of policy development processes to link design and implementation.

1. Involving implementers in policy design

The pace of some changes in South Africa may explain why those responsible for their implementation were little involved in their development. However, there seems to have been a more general split in policy development, also reflecting the common experience of many countries, between those who design policies and those who implement them, as well as very limited consultation with implementers at any time. As a result the free care and resource allocation policies poorly considered implementation needs, resulting in unexpected and avoidable impacts. Yet implementation is not a separate activity but a part of the policy development process. Any division between policy-makers and implementers is artificial.

Implementers have to be involved in the actual design of policies in order to ensure that implementation needs are built into design, avoiding wasted time and resources at a later date (Crosby 1996). This may be especially important in politically decentralised systems in which implementers have to reconcile national policy decisions to local imperatives. However, it may be more appropriate for implementers to act as advisers in the policy design phase given the many other issues that must be considered then, whereas in planning for implementation they need to have a more central role. In either case it is also important to acknowledge that health care managers and providers, the implementers, have interests and concerns just like other actors and these may differ from policy-makers and policy designers. Managing providers and, in particular, building the degree of implementer support required to enable change can, therefore, be equally as important in effective policy development as

developing strategies to engage interest groups (see Box 10.1). Management options, therefore, also include adaptation of policy design in ways that promote support (e.g. by giving incentives to implementers) as well as developing careful strategies of working with this group.

2. Strengthening the link of 'special policy processes' to implementation

South African experience suggests that the implementation of recommendations from special policy processes is much more difficult than of those developed through routine processes, such as the budget cycle. Whereas routine processes generally have an in-built implementation sequence, special processes must explicitly consider issues of policy design as well as implementation steps.

It will also always be critical to identify a 'policy champion' from within government structures who can move the recommendations of special policy processes (and, perhaps, even routine structures) towards implementation. The lack of a policy champion is one reason given for the slow implementation of the Hospital Strategy Project's recommendations even though these included specific ideas on implementation. Such a champion might be an individual or a special implementation unit. The champion's organisational location must give access to relevant, key points within government structures and processes, and s/he must have both political status and adequate technical, capacity to fulfill her/his task (Gilson and Travis 1997).

10.3 Strengthening implementation directly

This section provides further recommendations about how to strengthen the implementation of policy proposals. They are drawn from, and closely linked to, the conclusions presented in **Chapters 7 and 9**. Specific, related recommendations for South Africa, again focusing particularly on the development of SHI and norms and standards, are again presented in Annex 10.2.

10.3.1 Working within a changing policy environment

1994 produced a window of opportunity for South Africa to execute far-reaching reforms to tackle the grossly inequitable and inefficient health system it inherited. Yet the accompanying and radical upheaval in the policy environment itself contributed to problems with the implementation of reforms. Structural change and institutional flux, in particular, undermined the capacity both for policy development and for policy implementation which, in turn, weakened the impact of the reforms.

Although the extent of change is perhaps peculiar to South Africa, some changes are similar to aspects of the institutional change being experienced elsewhere. For example, civil service reforms and changes in the role of government in social sector service provision have the potential to affect the governance and administrative systems of many countries (Cassels 1995). The policy environment of South Africa will continue to change during the next government's term of office, as new governmental structures evolve and develop. The emerging role of local government is likely to be particularly important to governance and administration across all sectors.

In a changing structural environment it will be particularly important to recognise the costs of 'trying to do too much too quickly', even whilst accepting that problems demand urgent action. When institutions are being reformed and new lines of management and roles and responsibilities are being developed, policy making must begin with those changes that can be accomplished and will generate positive impacts. Developing the capacity for future policy development and implementation is also likely to be an important building block for

continuing reform. Systems should be developed which can be responsive and flexible to change. It may be pointless to initiate a particular reform if the policy environment is likely to shift completely and negate the policy option or undermine its utility. The strengths and weaknesses of South African health care financing policy implementation in this respect suggest two lessons. First, the priorities for policy action must respond to concrete and identifiable problems as well as build political support for a broader reform agenda (as may have been the case in relation to both free care policies and health sector resource reallocation). Second, these priorities must be rooted in clear analysis and understanding of key health problems, how reforms might address these problems and the sequencing of policy actions required to support the implementation of complex reform (unlike the experience of SHI development).

10.3.2. 'Enabling' implementation through leadership

Health financing reforms can only meet their objectives and ensure sustainability when they are implemented well. The South African experience highlights problems of leadership as well as other capacity problems, such as weaknesses in skills and systems. These have, in turn, been exacerbated by economic and structural constraints. Such problems are common across countries and settings (Bennett *et al.* 1996; Hilderbrand and Grindle 1994; Leighton 1996).

The leadership required for implementation not only involves careful priority setting, as discussed above, but also the approach of facilitation. The governance structures of South Africa emphasise the need for such an approach as policy action requires action across both national/provincial and provincial/local government spheres. The experience of collective planning by the PHRC in the development of health conditional grants provides a foundation for further coordinated action across provinces. However, past experience in South Africa has particularly pointed to the weaknesses of strategies for consulting with the providers who, ultimately, bear the brunt of health system change. Effective implementation is, in general, rooted less in control and more in co-ordination. As noted from wider experience, *"Although control over the actions of all agencies involved in implementation may be unnecessary (or indeed impossible), nevertheless, it is important that agencies be aware of what the others are doing and that they coordinate their actions – both to avoid being at cross purposes as well as to provide information concerning important results which may affect the implementation strategy and actions of another agency"* (Crosby 1996: 1411).

Effective implementation in South Africa requires, therefore, a clearer division of responsibilities between government institutions at different levels (e.g. national, provincial and district). Key groups at each level must be informed about what is expected of them, and responsibilities need to be backed up with the necessary human resources, management systems and other resources. There will also need to be a two-way process of communication to support implementation. Often, the health system looks very different from lower levels and reform implementation may well change with this perspective. To build the capacity that is needed may also require additional training. Identification of trainers and training institutions then becomes very important.

In developing the 'capacity to implement' it will also be useful to think through whether and how to pilot and phase reforms, as discussed below. Although the pressing need for change in South Africa has required fast action, more gradual implementation can support more effective implementation by allowing the necessary capacity to be developed as part of the process of implementation (Gilson and Mills 1996; Gilson 1997b; Kohlemainen-Aitken and Newbrander 1996; Mogedal *et al.* 1995). Implementation can then become a two-way learning process between policy makers and implementers.

10.3.3 Planning for implementation

The general experience of implementing financing reform in South Africa also reflects the common failure simply to plan for the specific tasks of implementation.

1. Carefully taking advantage of ‘windows of opportunity’.

One of the successes of the South African reform process between 1994 and 1999 was the range of policies implemented quickly to take advantage of a ‘window of opportunity’ for change. This ‘window of opportunity’ in South Africa was clearly associated with the broader political transformation of the country. In other countries similar opportunities may result from political cycles that bring new governments to power, or affirm the position of an existing government (Glassman *et al.* 1999; Reich 1996; Walt 1994).

However, the pace of change during a ‘window of opportunity’ may, as in South Africa, itself force implementation mistakes. It may even, perversely, cut away government support if seen to have negative impacts. Public concern about the impact of the free care policies and, more importantly, perceived declines in the quality of public hospital care have, thus, detracted to some extent from earlier support for health policies in South Africa.

It is, therefore, always important to plan for implementation even whilst taking advantage of such opportunities. Such planning might include risk analysis of the adequacy of capacity and the potential for opposition, identification of key potential obstacles and ways of tackling them, as well as preparing guidelines to support implementation. Flexible and gradual implementation approaches that allow policies to be adapted in response to experience are also important. Phasing and piloting of reforms may help their ultimate success, whilst monitoring and evaluation are vital for improving reform implementation.

2. Recognising that complex policies can create implementation problems

By their very nature, financing reforms are often complex in execution and impact (Paul 1995). Where they involve the creation of new institutions or new ways of performing tasks, as with SHI and the development of norms and standards, they may be particularly difficult to implement. Adequate time and resources need to be devoted to such concerns: short deadlines tailored to meet the demands of political cycles may be counter-productive. Nevertheless, it may not be possible to go beyond a certain level of detail in formulating an initial policy design and it may be necessary to resolve certain details in, or parallel to, its testing (Leighton 1996). Piloting aspects of reforms may generate lessons for further implementation, while phasing reform implementation can allow problems to be identified and addressed even during implementation.

It is also likely to be necessary to work towards complex reforms in stages, through the sequencing of individual actions that taken together represent the overall reform. The problem associated with such a strategy is that the policy environment may change and leave the complex reform only partly implemented. Hence careful planning of the sequencing of reforms becomes critical. Reformers must ask whether the individual steps toward the reform meet objectives in themselves. If not, then the cost or risk of failing to implement all the steps must be considered beforehand. Similarly, it may be necessary to plan well in advance for future steps, particularly in terms of capacity development and available resources.

10.3.4 The importance of monitoring and evaluation

Well functioning monitoring and evaluation (M&E) systems are essential for any health financing reform, providing data that allow policies to be improved over time and so strengthening their potential to meet their goals (Crosby 1996; Gilson 1997b; Leighton 1996). The absence of monitoring and evaluation, and limited use of available evaluation data, was highlighted as a barrier to past implementation of all health financing reforms in

South Africa. The evaluation of the first free care policy could, for example, have benefited implementation of the second free care policy. M&E is particularly important, although difficult, in data-scarce environments such as South Africa and, as highlighted in section 10.4, has an important role in informing future policy design.

M&E systems intended to support policy implementation, particularly the implementation of complex system-wide change, must allow assessment both of the progress towards objectives achieved by any policy change and of the factors influencing the progress achieved. Understanding the relationships between a policy change, consequent processes and final outcomes “*provides a better basis for making useful recommendations to policy-makers ... [and]... enhances the validity and credibility of the data and thus the probability of making an impact*” (Gross *et al.* 1998: 107). In any case the complexity of system reforms, that are usually initiated in a context of broader change, not only make it very difficult to draw causal links between policy change and impacts but also point to the need for comprehensive methodological frameworks (Janovsky and Cassels 1996). The framework and approach of this study provides one structure within which to develop more detailed M&E frameworks that take account of these dual needs and of the particular influence of actors and context.

A critical element of further evaluation in South Africa, and elsewhere, in support of equity-promoting policies is to develop a better understanding of the public’s views on reforms (Gilson 1998b). For example, were the free care policies seen as positive because they, in principle, improved access, or more broadly because they strengthened the government safety net provided to the poorest groups in society? To what extent were these potentially positive views offset by problems experienced in accessing care? And how do public views on these sorts of issues inform the development of, for example, SHI? Such analysis can, thus, both inform understanding of the impact of reforms as well as providing an important, and often over-looked, input into future policy development.

10.4 Strengthening policy design

The analysis of this study suggests that the priorities for future health care financing policy action in South Africa are the:

1. development and implementation of norms and standards that can influence allocations by provinces to the health sector;
2. development and implementation of procedures for allocating public health resources within provinces towards areas and groups in greatest need;
3. development and implementation of a comprehensive financing reform that seeks to achieve some cross-subsidy from the private to the public sector (and to reduce some of the cross-subsidies which currently work in the opposite direction);
4. development and appropriately timed implementation of supporting changes to strengthen the organisational capacity of the public health system – such as strengthening revenue collection and hospital management;
5. monitoring and evaluation of implemented financing policy changes, such as health conditional grants and the 1998 Medical Schemes Act.

Recommendations for strengthening policy design in relation to four of these five priorities are presented in the following sections. They are guided by analysis of the actual and potential impact on equity and sustainability of the financing policies proposed and implemented in the 1994-99 period, and by the analysis of how design features help explain impact (see **Chapters 5 and 6**). They include some that reflect on the processes through which policy is developed, emphasising that the development of policy can never be disconnected from the manner in which it is developed. A foundation for further policy

development in any area will be clarification of the overall equity goals of the health system, including consideration of how financing and delivery policies interact in order to allow these goals to be achieved.

As parallel analysis by the study team has both emphasised the importance of intra-provincial resource allocation and provided some pointers for future policy action, the issue is not considered further in this section. (See Brijlal *et al.* 1997; Gilson *et al.* 1997; Gilson and McIntyre 2000; Makan *et al.* 1997; McIntyre *et al.* 1999; McIntyre and Gilson 1999; McIntyre and Gilson forthcoming).

10.4.1 Improving the geographic equity of health care spending

1. Using the lessons of past experience

The experience of implementing a health sector resource allocation formula through the Function Committee offers some lessons that remain relevant even as South Africa's overall resource allocation policy continues to evolve (see Box 10.2). They are also useful to other countries within which resources are allocated via the central Ministry of Health to health managers within geographical areas and/or facilities.

It is also particularly important that the methodology for calculating health conditional grants is strengthened, based on clearer principles and better data. Particular attention needs to be given to establishing priority needs for tertiary and quaternary care within very tight resource constraints, as well as linking capital development to these needs.

2. Clarifying future policy options in South Africa

As progress towards equity in the distribution of health sector resources has slowed since the advent of fiscal federalism, it is important to develop a mechanism for promoting equity within the health sector in the context of unconditional provincial block grants. Most policy attention is focused on the development of the norms and standards allowed by the constitution. For the health sector, van den Heever and Brijlal (1997: 87) recommended that:

“norms and standards relate to the package of services to be made available by the state ... they establish the official distinction between what can be regarded as essential and discretionary health services”.

Box 10.2: Lessons from the South African Health Function Committee formula that reflect and reinforce international experience

Broad support for the principle of redistribution is critical

Redistribution between geographical areas or levels of care in any setting is a political action and can only be effected successfully if it has broad support. Such support is also important in countering the inevitable challenges to the design that will result from scarcity of data in most low and middle income country settings.

A strong central role is essential

Although the sub-national levels of any health system are critical in health care management and delivery, resource reallocation will always require a strong role for the centre. Although not necessarily requiring wholly centralised determination of health budgets, it is critical that the centre always monitors progress towards policy objectives and revises policy guidelines as appropriate. It is particularly important to monitor the impact of contextual changes (such as decentralisation, macro-economic policy and budgetary reform) on resource allocation patterns.

The policy objectives of a formula must be clear and explicit

In developing countries health planners have to manage a fairly complex process of shifting resources between regions while *at the same time* shifting resources between levels of care. This requires explicit policies on the relative priority of different sorts of services.

The policy objectives of a formula must be consistent with other health service policies

A needs-based formula should complement other strategies for health sector reform. Most importantly in middle-income countries, the formula should take account of policies on the private health care sector. Likewise, policies that enhance the impact of the formula should be implemented in parallel. These include policies that prioritise services and focus on preventive care, ensure equitable access to scarce services, reform financing and management mechanisms and create positive incentives to utilise resources efficiently.

Reasonably accurate population data are critical to formula design

Population data are a pre-requisite of formula development. Where such data are weak, resource re-allocation using a formula should be undertaken gradually to prevent target budgets changing with data sets in ways that impact significantly on health care delivery. Other methods of determining resource needs may also be useful in informing the overall process of resource reallocation.

The formula should attempt to estimate need for health care accurately

Needs-based formulae are usually controversial. This is partly because of the difficulties associated with measuring need. Acknowledging the complexity of the problem of estimating need, and that data sets are limited in low and middle-income countries, it should still be possible for such countries to go beyond simple per capita calculations to include other indicators of need. Methodologies can be developed on the basis of existing data and explicit assumptions, and continually updated, as improved data become available.

Special allocations should also be estimated using sound methodologies

Most needs-based formulae include calculations for special allocations that are not distributed on the basis of need (such as allocations for training activities, highly specialised services, cross-boundary flows and the special costs of service delivery in different areas). These allocations, which can also be controversial, must be based on a methodology as rigorous as the methodology for structuring the formula itself.

The pace of budget reallocation must be realistic

A realistic pace of budget change should be adopted to ensure health sector sustainability and to reduce opposition to the process of redistribution. Guidelines concerning the 'ceilings' and 'floors' on percentage annual budget increases and reductions, respectively, are useful in this respect. It is particularly important not to attempt to redistribute resources too rapidly when formula design is still being refined and while data inaccuracies exist.

The time frame for implementation of the formula should be feasible

The formula itself sets target budgets. *Annual* shifts in budgets should be determined by other factors, however. When there is sustained growth, the development of under-provided services can be achieved mainly through using growth funds. When there is no growth, resources have to be shifted from existing services. This is difficult when redistribution requires, for example, that health workers move to less attractive areas of employment, and facilities be built in remote areas.

The formula should be adapted when necessary

When conditions change or when the formula becomes inappropriate it must be reviewed. Any changes introduced for subjective or political reasons should be acknowledged explicitly. Changes to the formula should not cause major disruptions to health services, as the goal is to provide a medium- to long-term framework within which health service managers can plan the rational and sustained transformation of services.

The implementation of the formula should be accompanied by sound health services planning

A formula determines how funds should be distributed fairly between regions. It does not provide guidance on how to translate funds into resources such as personnel, pharmaceuticals, facilities and equipment that are distributed at the district level in the service of high-priority care. The reasons for this relate to a host of problems in operationalising equity, particularly in developing countries. For example, changes in the distribution of facilities and even personnel are not effected easily, and there are numerous and subtle barriers to access, including income, class and race. Purposeful planning is required to ensure that disadvantaged populations receive improved health care. As the capacity to link policy-making, budgeting and planning processes into a sound development strategy is often weak in developing countries, active steps should be taken to develop relevant skills.

Adapted from: Doherty and van den Heever, forthcoming

Alternatively, norms and standards could take the form of staff to population ratios, in line with the approach adopted in the education sector (see Box 10.3)

In either case, it is important that the norms and standards established are compatible with national affordability criteria, so that provincial Treasuries can realistically be expected to fund the services from their unconditional block grants. If not, these norms and standards could become 'unfunded mandates' constraining provincial action (see **Chapter 9**). In addition, it is important to consider which services the norms and standards should cover. The most likely focus, given the hospital basis of conditional grants, is on the priority primary care services delivered through the District Health System. However, if the mandated primary care package requires budget allocations greater than existing levels for the services it incorporates, and the overall provincial budget is not increased, spending on what could be seen as 'discretionary services' (that is, those covered neither by norms and standards or conditional grants) may be reduced. This would, in particular, impact negatively on the referral services that are critical in the provision of effective primary care. On the other hand, if norms and standards are specified as covering all services except those funded through conditional grants, the provincial Treasury's power to determine the health sector's budget would be significantly undermined.

A critical first step in developing norms and standards is, therefore, conceptual clarification around the terms 'essential' and 'discretionary'. For example, should these terms be defined as particular levels of care, or rather as packages of services across levels of care? Such clarification may also need to be linked to any parallel process of determining the benefit package to be offered within a social health insurance system.

Box 10.3: Norms and standards in the education sector

Two sets of norms and standards within the education sector are designed to promote intra-provincial and inter-provincial equity respectively:

- National norms and standards for school funding - In terms of this norm, all schools within a province are allocated into income quintiles on the basis of income and poverty levels in the community surrounding the school. This norm requires that 35% of each province's education budget must be allocated to the poorest quintile of schools in that province, 25% of the resources to the second poorest quintile of schools, 20% of resources to the middle quintile, 15% to the second richest quintile of schools and 5% to the richest quintile. The key criticism of this 'School funding norm and standard' is that it does not take sufficient account of the extent to which currently advantaged schools can generate extra-budgetary resources.
- Norms and standards on post provisioning - The National Department of Education recently reached agreement with the major trade unions in this sector on post provisioning. It was agreed that:

- * Provincial Education MECs will set learner:educator (pupil:teacher) ratios based on affordability within their budgets;
- * Provincial education departments then inform schools what their staff complement should be;

- * School principals identify surplus posts in consultation with their staff; and
- * Surplus and temporary teachers have to apply for posts where vacancies exist (either in their own or another province). If they unreasonably refuse to accept a position, they will be deemed to have resigned.

This norm has been criticised as it still allows for differences in pupil:teacher ratios between provinces.

While there have been some criticisms of the design of the education sector's norms and standards, it should be acknowledged that education is the only sector to have made any progress in the development of norms and standards to date. This is even more laudable, given the intense negotiation with relevant trade unions required to introduce the regulations on post provisioning.

Source: Brijlal 1999

As health sector norms and standards are developed it will also remain important to review and revise appropriately, the formula used by the Department of Finance in allocating the unconditional block grants. A particular concern is the impact of the 'economic output component' on the equity of resource allocations across provinces (see also McIntyre and Gilson 1999). A parallel mechanism for promoting equity would be through introducing equity-oriented criteria into the MTEF process (see section 10.3.3).

Finally, as generally highlighted in Box 10.2, it is always important to monitor the impact on geographic equity and level-of-care spending patterns of resource allocation policies. Such assessment of the existing conditional grants, as well as any new policies developed in the future, will be critical in informing further policy development.

10.4.2 Achieving cross-subsidies from the private to public sectors

1. Using the lessons of past experience

Although no N/SHI proposal developed in the 1994-99 period was implemented the experience of developing the reforms and analysis of the proposals' potential impact on different actors highlights a number of important policy lessons (see Box 10.4). These are relevant both to South Africa as it continues to develop policy proposals in this area, and for other countries considering SHI-type reforms.

2. Clarifying future policy options in South Africa

Health financing policy developments in South Africa over the 1994-99 period were clearly guided by the understanding that the inherited socio-economic and racial inequities in health care expenditure were intolerable. Although still important, three arguments appear to be promoting a review of the extent of redistribution that can and should be pursued:

- taxation levels are already high in South Africa, especially with regard to middle-income earners (this view has also been supplemented by the argument that, seen together, existing payments towards social security-like benefits - such as pensions, unemployment insurance and the Road Accident Fund - may also be high);
- tax payers, especially in the mid- to high-income categories, contribute to public services through taxation but seldom use these services - it is, therefore, 'unfair' to expect them to contribute further amounts to public services;
- redistribution through mechanisms other than taxation (such as Social Health Insurance) is inappropriate.

However, particularly given the array of cross-subsidies from the public to the private sector, these arguments may overstate the existing progressivity of health care expenditures. In addition, the analysis presented here (see **Chapter 6**) suggests that the 1997 SHI proposals are likely to have the least impact on current inequities of all the options so far proposed in

South Africa. This is of particular concern given that international experience indicates that there are a myriad of ways in which SHI design can aggravate existing inequities - or introduce new ones - within certain population sub-groups, as well as impact on efficiency and sustainability (see Annex 10.3). Kutzin (1998: 73) cautions that, in general, “*(e)vidence reveals a large gap between the desired effects of insurance expansion and actual observed effects*”.

Although simply not an easy task, better information can inform further policy development in this area. More information is particularly important in considering whether the partial insurance cover brought by SHI can be implemented to the benefit of the poorer groups in society or, at least, in ways that do not disadvantage them. Four specific analyses that can help in this task are outlined below – and a detailed summary of recommendations is provided in Annex 10.4. They are also relevant for any country concerned about the equity impacts and political acceptability of introducing SHI.

Box 10.4: Lessons from the South African experience of developing SHI proposals that reflect and reinforce international experience

Secure and demonstrate political commitment

Governments wishing to embark on SHI reforms must be generally active in defining health policy, developing frameworks for the funding and provision of services and monitoring the achievement of objectives. Demonstrating commitment in these ways is important in countering the potential resistance of influential interest groups, maintaining momentum in the long process of designing and implementing SHI reforms and developing a SHI scheme that supports the achievement of societal goals. It is particularly important to demonstrate a commitment to using insurance expansion as a means to increase government resources for the disadvantaged in order to prevent SHI from simply becoming a mechanism for increasing the benefits of the already advantaged.

Build on societal characteristics

The likelihood of SHI being an acceptable financing option is enhanced in societies that as a whole believe in the social objective of equity. Likewise, societies that generally accept the principles of consensus-building, partnership and collaboration in designing public policies will be better able to deal with the complexities that SHI poses. Societal characteristics will also affect the design of SHI: for example, the extent to which the private sector is involved in an SHI scheme may depend on whether the society as a whole favours market-oriented delivery systems. Lastly, it is preferable that countries where SHI is being considered should have experience of paying for services through user fees or risk-sharing arrangements (such as voluntary insurance).

Accept a slow process of development and negotiation

The development of SHI depends on the building of consensus and support for the new scheme. Hence, patience and commitment are required. Planning also needs to be detailed and thorough. International experience has shown that this process - as well as the phased implementation of increasing coverage - needs to be slow in order to avoid derailment. Most countries trace the evolution of SHI to more than half a century. Pilot schemes, limited coverage or limited benefits may be mechanisms for introducing SHI cautiously.

Be prepared for strong interest groups to attempt to block reform

Powerful interest groups are affected by SHI and tend to lobby government intensively during the planning stage of a new SHI. These interest groups also lobby intensively for the modification of the SHI design after implementation. It is important for government to understand the explicit and implicit objectives of these stakeholders with respect to SHI, and to form strategic alliances with some groups in order to push through certain aspects of the reform. Broad consultation can also help to ensure that the scheme is designed feasibly and to prompt more open discussion. On the other hand, government needs to set limits on the degree to which it is prepared to compromise, and to resist stakeholders that wish to distort the SHI scheme to their own ends. Good negotiation skills are required in government to minimise the conflict that may arise around discussion of SHI.

Adapt SHI to the opportunities/limitations posed by the broader economic context and structure

SHI tends only to become an option in countries that have a relatively high per capita income, and are more popular in times of rising employment. In these settings, more money is available for health care spending, and government expenditure on health care tends to have a higher relative priority. This facilitates the development of SHI schemes that in general tend to deliver fairly sophisticated services

at a fairly high administrative cost. As it is difficult to determine incomes and raise SHI payments from the informal and agricultural sectors, SHI schemes are often limited to the formal sector which must be large enough to create opportunities for cross-subsidisation opportunities within the scheme and to the uninsured, take a noticeable load off the publicly funded services, and justify the major administrative effort required to establish a scheme. However, even where the structure of the labour market is favourable, the administrative costs associated with SHI schemes may become a deterrent if health care spending as a proportion of GDP is already high, unless the scheme is able to contain costs adequately.

Consider the affordability of SHI to employers

SHI schemes must not impose contributions that will bankrupt employers or burden them to the extent that they reduce their numbers of employees (before this happens, however, employers tend to shift costs onto wages or prices). Of relevance are general levels of taxation on business, the proportion of the SHI contribution that is to be paid by the employer, and the amount of money that they were already spending on their employees' health care costs.

Ensure that the health care system can deliver services of adequate quality

There should be an adequate network of facilities for members of the scheme to use. Services should be of an acceptable quality. If there are not enough facilities or the perceived quality of care is low, people will be reluctant to join the scheme, particularly if they already have free access to these services. Conversely, if people really want to join the scheme because of the services to which they gain access, it is that much easier to achieve compliance in contributing to the scheme, especially when employees put pressure on their employers to provide benefits.

Co-ordinate SHI development with other policy formulation

There are numerous policies which impact on SHI, or which may be affected with SHI. The development of SHI should thus occur within an active process of ensuring appropriate linkages with other policies. As many policies, apart from SHI, take years to develop and implement, this co-ordination should start early in the process of designing an SHI scheme.

Develop capacity for implementation

One of the most important prerequisites for SHI is a sufficient level of skills within the country. This capacity is required at a number of levels. First, in the design and implementation of a scheme government requires skills in areas such as data collection and analysis, the economics of incentives and provider behaviour, accounting, management, financial planning and negotiation. Second, the government must have the ability to codify the scheme in law and to enforce it, otherwise the mandatory nature of SHI, upon which many of its benefits are dependent, will be eroded. Third, there must be systems for assessing incomes for the purposes of payroll deductions. If the country already has an existing progressive tax system, it becomes easier to integrate and collect a progressive SHI premium. Fourth, there needs to be a history of financial integrity in the private and public sectors to ensure that the SHI scheme is not likely to be subject to corrupt practices. This is more important in the case of SHI than private insurance because in many cases contributors do not have the option to opt out of a scheme if it is mismanaged. Lastly, the user population must have general levels of literacy and numeracy in order to understand and appreciate the benefits of a proposed scheme, and to utilise it to their advantage once it is operational. Overall, capacity to understand, administer and utilise the scheme has to be consistently developed over time. As capacity building can take years, it should start well in advance of the actual implementation of the scheme.

Benchmark policy designs and evaluate SHI against chosen objectives

SHI can have many unintended consequences. Hence, its implementation must be actively monitored and evaluated against criteria such as equity, efficiency and sustainability. This requires a clear sense of the original objectives of the SHI scheme. Even in the design phase of SHI, its design features need to be clearly benchmarked against these objectives lest the changing nature of the debates around the design undermine these objectives. Where there is uncertainty around the ability of a scheme to deliver its key objectives, implementation should be avoided given the enormous complexity and cost of SHI as a reform.

Adapted from: Doherty 1997a

1. Comprehensive analysis of the extent of cross-subsidisation in health care spending, taking into account the extent of progressivity in the tax system as well as the benefits that accrue to different income categories (i.e. considering both financing and benefit incidence). Income and company tax, value added tax, tax deductions for health insurance contributions, contributions by government to civil servants' health insurance premiums, and public subsidisation of hospital fees charged to private patients all need to be taken into account.

Such analysis has importance for all health policy development in South Africa – and in other countries concerned with the degree of equity achieved by their existing health system.

2. As decisions around the appropriateness of cross-subsidisation have both technical and philosophical foundations, technical analysis should be complemented by conceptual work around the motivations and objectives of cross-subsidisation in health care spending within the context of South Africa's past history and present social objectives. The analysis would need to consider the extent of cross-subsidisation that might result from future social security payments in general, in order to respond to concerns that, in combination with taxation and social security policy, health financing policy places inappropriate demands on middle to high income earners. It will also be important to consider whether any form of tiering within public hospitals, in support of SHI, is perceived to be acceptable. Such tiering might take the form, for example, of hotel amenities like private wards and improved food, or separate (and faster) queuing systems and might have broader consequences, such as encouraging the middle income to use public services and then demand better quality.

3. The next step of analysis should consider what degree of cross-subsidisation would be generated by different SHI options (especially, in South Africa, the 1997 proposals). This would include, in any setting, analysis of the progressivity of the contribution structures of different options, with an estimate of the extent to which contributions will replace existing out-of-pocket or other expenditures on health care. Estimation of the net change in public sector resources for health care following the implementation of any option is also important, and must consider, first, how much revenue would be required to fund improvements in hotel facilities for SHI members. In South Africa, this funding requirement must also address the nature of improvements required given the perceived quality shortfalls of public hospitals and the parallel growth in use of private hospitals. Another factor peculiar to South Africa that must be considered is the expected increase in tax revenue contributions to SHI for civil servants given that approximately only half of them and their dependents have medical scheme cover.

4. In clarifying the SHI options feasible in South Africa, as elsewhere, it is, finally, important to consider the acceptability of any option to key actors (see Box 10.4). Although much attention was previously paid to understanding how SHI would impact on the private sector, particularly financial intermediaries, little is understood about the impact on employers (with respect to employment practices) or on employees and Trade Unions (with respect to affordability and political acceptability). Will SHI be acceptable in the context of large geographical disparities in the quality of the public hospitals and in the absence of a well-functioning hospital fee collection system or a policy which allows tiering of care (at least for hotel amenities) for private patients in public hospitals? The analysis presented in **Chapter 8** is both an example and a foundation for such work in the future.

3. Developing the design of chosen policy options

Once an SHI option has been selected a vast amount of technical work is required to prepare the policy for implementation, including designing collection, reimbursement and administrative systems. Two design characteristics of the 1997 South African proposals are particularly important to review:

- the separation of the SHI fund from the medical schemes environment – including review of the risk-equalisation mechanisms that are necessary to make both a state-run SHI fund and the rest of the medical schemes industry as it will be structured under the new Act, viable;
- whether PHC cover could be re-introduced into the SHI benefit package in order both to promote allocative efficiency through SHI and to allow contributors the option to choose private providers – including review of the extent to which private PHC services are

already being used by potential SHI beneficiaries and of the value of allowing SHI members to use private hospitals (at SHI rates) when no appropriate public care exists locally.

Some progress has been made in developing a national uniform hospital fee structure and some provinces are beginning to implement some form of revenue retention. However, other aspects of hospital fee policy reform still requiring attention include:

- The development of a mechanism to collect more timeously and easily fees which are presently charged to medical schemes for members using public hospitals but which, due to a variety of factors - including late submission - are not reimbursed to the hospitals;
- The development of a nationally co-ordinated revenue retention policy which provides incentives for fee collection at the hospital level, whilst also supporting the equitable re-distribution of resources between geographic areas and levels of care. This policy should consider how revenue raised through fees would impact on budgetary allocations to collecting facilities/areas;
- Re-design of fee collection systems.

Assessing the existing and differing experiences of provinces in implementing change in these areas will provide important inputs for further design development.

4. Using evaluation to inform policy design

It is particularly important, first, to evaluate the impact of the 1998 Medical Schemes Act over time. In the absence of mandatory SHI (which increases the size of risk pools available to financial intermediaries) and risk-equalisation mechanisms (which equalise the risk confronted by different financial intermediaries), medical schemes may find themselves confronted with a high-risk environment that has the potential both to destabilise the industry and worsen coverage. Four main activities are recommended:

- Evaluation of any risk-selection practices by financial intermediaries that persist following implementation;
- Evaluation of any changes in the equity of coverage that arise from the above practices (or others, such as changes in levels of premiums or content of benefit packages);
- Evaluation of changes in the relative utilisation of hospital services (covered by the 1998 Act) and PHC or community-based care (not covered by the Act), in part as input into the development of SHI proposals and, in particular, benefit packages;
- Evaluation of the financial sustainability of financial intermediaries under the 1998 Act and its associated regulations (including whether efficiency of resource use is indeed prompted through the form of competition that the Act attempts to stimulate).

Second, the equity impact of the new uniform fee structure, in the context of the analysis of the overall progressivity of health care, as well as net revenue generation levels must be assessed. Such assessment can, together with review of how fee structures can be adapted (especially through simplification) to deal with practical difficulties in fee collection, such as difficulties in determining patients' income or collecting outstanding debts, feed back into policy re-design as appropriate.

10.4.3 Developing a comprehensive package of linked reforms

International experience highlights the important inter-linkages between different financing reforms, and between these reforms and other health sector reforms (Box 10.5 lists, for example, the range of reforms pertinent to SHI policy; see also Box 10.4). If these linkages are designed well, and the process of implementation 'sequenced' appropriately, health

financing reforms stand a greater chance of achieving their objectives. If linkages are structured poorly, the objectives of reform may be undermined.

Box 10.5: International experience concerning the financing and other reforms required for effective implementation of SHI policy

Financing policies:

- user fee policy
- alternative financing policies for the uninsured but not indigent
- financing policies for special services (e.g. compensation for work-related or motor vehicle accident injuries)
- policies to improve allocative and technical efficiency in the public sector (e.g. public hospital management reform)
- geographic resource allocation policies
- public hospital reimbursement policies
- appropriate linkages with general taxation policy, including tax incentives
-

General health policy and organisational policies:

- legal and regulatory frameworks
- the expansion of services to accommodate SHI enrollees
- policies to ensure equitable access to a minimum package of health services
- the integration of publicly and privately funded and/or delivered services
- decentralisation
- pharmaceuticals policy
- appropriate technology policy
- human resource planning and development policy

Source: Doherty 1997a

The South African experience over the 1994-99 period highlights five specific areas where linkages between reforms could be strengthened in future policy development.

1. The linkage between hospital fee reform and SHI

Hospital fee reform is a vital prerequisite for the successful implementation of SHI (Barnum and Kutzin 1993; Gilson 1997a). At the same time, clear SHI policy proposals are required to allow hospital fee policy to be designed appropriately. For example, fee collection from patients able to pay for hospital care would be made much easier under SHI, obviating the need for complex mechanisms, such as means testing, to identify such patients. As any future SHI proposals are developed the linkage between these two policies should be reviewed to ensure they support each other.

2. The linkage between hospital and PHC funding

A stronger focus on the potential link between generating extra resources at hospital level (through improved fee collection and/or SHI) and resource mobilisation for PHC development might promote the acceptability of SHI in some actors' eyes. But further consideration must be given to the mechanisms through which additional revenue would be allocated within the health system (see below).

3. The linkage between financing reform and the MTEF

Two cross-provincial review processes could be enlisted to promote equity in health care resource allocation, namely the health sector MTEF Task Team and the recently established '4x4' structure. Although the Task Team has previously focused primarily on efficiency issues, it would be desirable to include equity as an explicit criterion for evaluating provincial health department MTEF submissions (McIntyre *et al.* 1998). Both the Task Team and the '4x4' could, for example, specify that provincial health departments must include

information on progress in addressing intra-provincial inequities in their MTEF submissions (as they are not able to directly influence inter-provincial health allocations). As the four finance department representatives of the '4x4' also serve on the Budget Council, the recommendations of the '4x4' are likely to have some credibility, potentially influencing the final MTEF recommendations of the Budget Council. Thus, the '4x4' could play an important role in placing health sector equity on the MTEF agenda.

4. The linkage between revenue generation and resource allocation policies

As new sources of finance become available to the health system, perhaps through new provincial taxes, user fees collected by hospitals, or an SHI fund, their allocation needs to be planned to support, rather than contradict, existing strategies for achieving equity and allocative efficiency.

5. The linkage between financial and other resource reallocation policies

Both infrastructural resources and human resources must be re-distributed to translate financial resource reallocations into the real redistribution of services. Capital and recurrent budget planning must, therefore, be mutually supportive of each other and so be brought together more effectively in relation to medium-term budget development.

In addition, there must be coherence between budgeting processes and decisions reached through bargaining processes that affect the cost of personnel. The newly established Health Sector Bargaining Chamber should allow better consultation with provinces and departments in determining remuneration and other conditions of service. But it may still be necessary to consider what role provincial bargaining forums could play in setting provincial salary levels for civil servants within a broad national framework (de Bruyn *et al.* 1998). While this could have adverse effects such as costly competition for skilled personnel, it would allow provinces to develop human resource policies to better meet the needs of their population. Such policies could include offering more attractive packages (containing both financial and non-financial incentives) to attract staff to currently under-served areas (e.g. rural and peri-urban areas).

10.5 Towards 'delivery': strengthening the policy process

This study has identified both the strengths and weaknesses of the process of financing reform development in South Africa in the 1994-99 period. Notwithstanding the considerable achievements of this period there are clear weaknesses in the design of the current package of financing policies, and in the processes that have been used to develop these policies. The design weaknesses are sometimes rooted in the process weaknesses. Although some of the process weaknesses are specific to the arena of financing policy reform, others appear to reflect more general trends in health policy development in this period. Action to tackle the continuing problems of inequity within the health system, as well as concerns about its sustainability, must combine specific pieces of analysis and design work with clear steps to strengthen the process of financing policy development and implementation.

What principles can guide the development of a process that will lead from policy change to change in delivery practices? Although there are no simple answers to this question, six key principles can be derived both from consideration of the South African experience over the 1994-99 period as well as the limited, relevant international experience. These principles are that:

- financing reform should pay attention to the 'art' of politics (rather than just the 'science' of technical analysis);
- financing reform should be placed at the heart of health system development;

- financing policy should be developed through a relatively open and transparent process (even though ‘closed’ decision-making is sometimes required);
- information is a critical element in financing policy development;
- the roles of different groups of technicians and analysts in financing policy development must be clear;
- implementation should be an integral element of financing policy development.

1. Financing reform should pay attention to the ‘art’ of politics

Seen as the preserve of the few with relevant knowledge, health care financing reform has often floundered because too little attention has been paid to the processes of reform development and implementation. This general lesson derived from international experience provided the impetus for this study, but has also been confirmed by the experience of South Africa between 1994 and 1999. This experience, therefore, affirms the plea of Walt and Gilson (1994: 366),

“Policy analysts cannot continue to ignore the how of policy reform”

2. Financing policy should be placed at the heart of health system development

Financing policy appears to have been seen as of less importance in South Africa than other aspects of health system development in the 1994-99 period. Priority was given to aspects of organisational change and specific interventions, such as drug policy, rather than a combined package of institutional and financing reforms.

Such an approach has been quite common in other countries in the past, as in the wide-scale implementation of single-focus user fee changes in many African countries (Gilson 1997a). However, broader packages of ‘health sector reform’ are now being implemented internationally. They are rooted in the understanding that wide-ranging change is required to tackle deep-rooted, systemic problems – as is found in South Africa. Such change can, in turn, only be implemented through an equally wide-ranging and coherent policy package (Cassels 1995; Gilson and Mills 1996; Frenk 1996; Londono and Frenk 1997).

Financing reforms are of particular importance within such a package because past and existing financing mechanisms have a wide-ranging influence over the provision of health care. They influence critical health system features such as:

- the balance between different levels of care within the system;
- the mix of inputs used in producing care (such as the balance between personnel and other items, or the relative weight given to technology within care provision);
- the spread of authority within the health system, and the degree of effective decentralisation;
- health provider behaviour and performance;
- the level and pattern of demand for different types of health care.

Thus, as identified in this study, historical patterns of resource allocation in relation to geographical areas and levels of the health care system are very difficult to change even where there is strong intent. These patterns, as well as other financing mechanisms inherited from the apartheid era, have a continuing influence on the efficiency, equity and sustainability of health care provision in South Africa.

Giving attention to the wide-ranging influence of financing flows and financial incentives does not, however, mean that they should be the only focus of efforts to improve health

system performance. Rather it allows consideration of how to support broader systemic change through financing change and of how to ensure that financial flows and incentives do not drive the nature of health care provision in undesirable directions.

3. Financing policy should be developed through a relatively open and transparent process.

In South Africa the financing policy proposals of the 1994-99 period were developed through a range of mechanisms but all of these were, in essence, quite 'closed' and opaque. Even where there was some public debate, such as during the 1995 Committee of Inquiry, it had little or no influence over the technical debates.

Two potential 'dangers' of opening up decision-making processes might be slowing down decision-making processes and losing control of the decisions. These are clearly important concerns for those seeking to drive quick changes in order to redress the vast, inherited problems of the past. Others might argue that broad support for the basic principles and lines of policy development was secured through the democratic election process. On election the job of government was then to implement the plans approved by the electorate. Some might even suggest that technical matters like health care financing policy development can only be undertaken by those with appropriate technical knowledge. The issues are simply too complex to be widely debated.

However, the electorate's views are of major importance in a democratic system and election debates rarely focus on the detail of any particular aspect of sectoral policy. In relation to social policy development no group, anyway, has the monopoly on 'truth' - there are only different views and perspectives of appropriate action. In addition, although all processes must aim for speedy action when appropriate, action for action's sake is likely to produce some unexpected, and perhaps unwanted, results (as with the initial free care and resource allocation policies). Closed processes may anyway become blocked or even generate opposition to change, as shown in the N/SHI debates.

In general, a combination of open and closed processes is likely to be important in generating sound and acceptable proposals within a democratic context. Open processes may have a particular role in allowing focussed debate about:

- the overall values and goals that should underlie health policy development and their interpretation into aspects of system design e.g. what does the pursuit of equity mean in relation to health care financing policy?
- the acceptability of the various policy trade-offs that might have to be made in the pursuit of, say, equity e.g. does the pursuit of equity require a 'one tier system' in the short-term or is it acceptable to allow some sorts of tiering within public facilities as part of a strategy of strengthening the system?
- the nature of the health care system that might best allow personal and societal goals to be achieved e.g. what is an acceptable balance between the public and private sectors?

The mechanisms or approaches that might be used to open up public debate on policy issues in South Africa include:

- a stronger role for parliamentary portfolio committees which themselves should have stronger links to community/citizen interest groups;
- strengthening the national consultative health forum as a forum for debate among a wider range of stakeholders on key issues;
- giving specific voice in these bodies to non-governmental organisations (NGOs) that represent less powerful groups (and taking steps to enhance their capacity to do this);

- supporting processes initiated by NGOs themselves– such as the ‘Speak Out on Poverty’ campaign conducted by the South African NGO Coalition in 1998 which allowed citizens and community groups in all nine provinces to share their experiences of poverty (Budlender 1998);
- the use of citizen’s ‘juries’ to debate specific issues, perhaps with a link to the media in order to publicise and promote that debate – for example, during the 1999 election campaign one newspaper established a representative panel of citizens who were asked their views on a range of specific issues, and these were then reported in the newspaper;
- establishing open commissions of inquiry as fora for public debate of specific issues.

All of these are mechanisms that have already been established or used in South Africa, and so represent realistic options. They clearly could not be tied solely to debate of health care financing issues, perhaps not even to health issues in some cases. However, specific financing questions could be debated within them and in relation to other aspects of systems’ development – generating views both on the specific issues and on the links between financing and broader systems’ change.

Government support for any or all of them would affirm their importance and value, helping to establish a climate of transparency and inclusion in relation to policy debate. It could also provide a signal to encourage civil society groups to initiate action themselves and to ensure that in more open processes of policy debate the voices of citizens are heard, rather than just the voices of powerful interest groups.

Closed processes, in contrast, may be useful in identifying policy options on the basis of publicly debated goals, as an input into further public debate – or in developing detailed design proposals in relation to specified options. Closed processes may also have value as part of a strategy to offset the power of specific vested interests. In the process of developing any policy there will always be a point at which debate must turn into action if change is to be implemented. In pursuing its broad mandate, a government must ultimately take responsibility for ensuring implementation of its preferred policy proposals (or for allowing and accepting no action). At this point, it will need to ‘strategise’ around how to include different actors, and such strategy should be developed with awareness of the interests each actor is likely to pursue and their potential support or opposition for specific lines of policy or proposals. It will also need to recognise when smaller technical groups need to be established to undertake the analysis necessary to allow policy development and/or to develop detailed and careful policy proposals.

Some of these sorts of more closed approaches have relevance in terms of the current state of health care financing policy development in South Africa. They can, nonetheless, be complemented by initiating wider public debate of changes being developed or already introduced. Thus there are calls to ensure that the budget monitoring activities of parliament are both strengthened and involve wider representation from civil society.

4. Information is a critical element in financing policy development.

Although policy-making is ultimately a political act, policy development can be informed, shaped and strengthened by information. International experience, thus, emphasises the need to ‘inform the reform process’ (Frenk 1996; Gilson 1997b). In order to pursue the ‘public interest’ politicians should seek to understand existing problems, alternative ways of tackling those problems and the impact of policy choices on the pre-existing problems. Public views on these issues are vital. Even though their decisions between options must ultimately reflect specific goals and values, decision-making in the public interest should be rooted in sound understanding of the specific issues of focus. One interviewee in this study, for example,

noted that not only “*is a spirit of compromise needed for a good process of policy-making [but also] good analysis, and a sense of what works internationally and what doesn’t*”.

Information is perhaps particularly important in a supposedly technical and complex policy area such as health care financing. Relevant information may be needed even to begin to think through how to proceed. The absence of widely available information may result in decision-making being monopolised by so-called experts.

A broad overview of the various sources of information that a government could draw into policy development is summarised in Figure 10.1. In quadrant 1 decision-making only involves the use of formal sources of information from within government, whereas in quadrant 2 information is generated almost wholly outside government but through formal processes. Quadrants 3 and 4, finally, point to the range of informal sources of information available to government decision-makers.

Figure 10.1: Sources of information for governmental decision-making

formal sources	
<p>(1)</p> <ul style="list-style-type: none"> • departmental research/inquiry • internal think-tank report • reports from internal experts <p>sources internal to government</p>	<p>(2)</p> <ul style="list-style-type: none"> • commissions • committees of inquiry • judicial review • reports from the legislature • commissioned research • formal consultation <p>sources external to government</p>
<ul style="list-style-type: none"> • informal discussions between decision-makers • gossip/rumour • informal use of advisers <p>(4)</p>	<ul style="list-style-type: none"> • discussions • consultation • reports • informal information/advice <p>(3)</p>
informal sources	

Source: Parsons 1995

This Figure highlights the potential role of some of the ‘open’ processes discussed above as sources of information for decision-making (such as commissions of inquiry), and the range of roles that technicians inside and outside government may play in relation to information generation. Interestingly the Figure does not specifically identify information from routine systems as a source of information. This may be because such data gives no insight into new policy options. These data are, however, critically important in monitoring the implementation of new policies, and so inform policy adaptation.

5. Roles of different groups of technicians and analysts in policy processes must be clear

The government technicians or non-government analysts who might play a role in health care financing policy development include economists, actuaries, lawyers, public health specialists, and management specialists. In South Africa the main groups who have been involved are largely those with health economics and public health training. Some are based in the Department of Health’s Directorate of Health Financing and Economics, or are scattered between other national departments and provincial departments of health, and others are based in academic units or private consultancy groups. Although part of a broader

health policy community, those with specific expertise are few in number, and so are likely to have to work together in some way. However, what are their relative roles?

The role of technicians working inside government is relatively clear. They are the government's primary advisors on health care financing issues, seeking to inform and guide relevant policy development in pursuit of government objectives. Such actions may require co-ordination or negotiation among different groups of advisors (for example, those based in the Department of Finance and those in the Department of Health), as well as co-ordination with other arms of government in implementation. These technicians are 'inside' both the formal and informal processes of decision-making.

The role of analysts outside government is, however, less clear. As one interviewee noted more generally *"I wonder if people have thought sufficiently about what role civil society actually can play in transition and is that role different from its long-term role, an independent role, and how does it play a role in a transition that sets up a capacity for that long-term role but that doesn't undermine that transition in the short-term ... I think it's got something to do with how one understands being a 'critical ally'. How you can be an ally of transition, an ally of the government, support them and at the same time maintain the right to be critical at times"*.

In thinking through the role of such analysts, including the team that has undertaken this research, it is, therefore, important to consider questions such as:

- what specific informational or other inputs to policy processes can they provide?
- to what extent should they become directly involved in developing policy, hand-in-hand with government officials?
- to what extent should they accept government policy lines and to what extent should they provide constructive criticism of these lines from their own perspectives?
- what other roles can they play in supporting policy development?

Perhaps some responses are more obvious than others. Analysts outside government may have the advantage of having more time to review, analyse and categorise information in ways that are useful for policy-makers. Trostle *et al.* (1999: 104), using the words of a Mexican government health official, suggest that research is valuable to policy-making because *"... what is needed for decision-making is the organisation of knowledge in such a fashion that allows us to see the options"*. Analysts may also be able to take a longer-view of needs rather than having to respond to the pressures of daily events and political cycles. They may play broader roles in raising understanding of issues and in formal training in relevant skills, in order to develop demand for the products of all technicians (Paul 1995).

To be effective in these roles, however, those from outside government cannot maintain too great a distance from the policy-making 'action'. They cannot take on the archetypal role of 'researcher as impartial adviser' – indeed, all researchers must recognise and make clear the values and biases that inform their analyses. In addition, they must engage with current policy problems and issues, and understand the operations of, and constraints on, government. Yet they must also learn how to balance the provision of support to government with constructive criticism provided at an appropriate time and in an appropriate manner. In order to undertake these tasks they need technical, communication and strategic skills (Trostle *et al.* 1999; Walt 1994). Perhaps above all, they must accept that *"empirical data from researchers are only one force among many, and therefore do not and cannot have the weight that outsiders – especially researchers – might want them to have"* (Trostle *et al.* 1999: 104).

Overall, the impact of any analyst or technician on policy is dependent on “*a strong degree of ownership or patronage for [their] output; the existence of a strong linkage to a dominant or significant policy-maker; the capacity to deliver high quality and technically sound analysis; a close congruence with the political and policy environment or a sense of what is politically, economically, and socially feasible; a relatively low degree of hostility from existing and/or competitive analytical units in other agencies; and sources of finance willing to adopt as neutral stance regarding the unit’s policy analysis agenda or methodology*” (Crosby 1996: 1413).

6. *Implementation should be an integral element of financing policy development*

Implementation is often seen as a specific activity that automatically follows policy formulation. Once a policy is developed all that needs to be done is to implement it. However, it may not be possible to implement a technically well-designed policy because its ‘design’ does not include consideration of how to implement it (e.g. SHI takes as given the institutional mechanisms required to strengthen hospital billing practices). Implementation may also be obstructed by an initial failure to develop ‘adequate’ support for it, failing to consider those whose support is necessary for its implementation (e.g. provincial Treasuries as well as provincial Departments of Health in relation to resource reallocation policies).

Any policy process must, therefore, include implementation issues as part of its focus, rather than targeting only the development of ‘a policy’. For example, Sabatier and Mazmanian (1979) identify six issues that should be considered during policy formulation to establish the pre-conditions for effective implementation. They are:

- a clear and appropriate understanding of how change can be brought about through the policy;
- clear and consistent objectives against which to evaluate policy change;
- identifying implementation structures that can motivate implementers to consider policy targets, and so implement effectively;
- involving committed and skillful implementers and ensuring they have adequate discretion to realise policy objectives;
- the support of interest groups, government and members of legislatures;
- adequate assessment of socio-economic conditions to try avoid a situation in which unexpected changes in these conditions undermine support for the policy or subvert the basis on which it was developed (i.e. the underlying understanding of how to bring about change).

The tasks of policy implementation, thus, include gaining legitimacy for the policy and building constituencies to support it, as well as clarifying organisational design, mobilising resources and monitoring. They are “*all strategic, not operational*” tasks, the critical “*first steps in either programme or project implementation*” (Crosby 1996: 1405).

In the quasi-federal structure of South Africa it is particularly important that implementation is not seen as the preserve or function only of provinces. National government must perhaps provide stronger leadership in the implementation of policies across the provinces, than in developing the policies themselves. The variable implementation of policies between geographical areas has, for example, clear dangers for equity (Collins and Green 1994), particularly as management capacity is itself distributed unevenly between provinces. The nature of South African governance structures also only emphasises that the type of leadership required for implementation is one that emphasises co-ordination and facilitation at all stages of policy development:

“The task of implementing policy reform is, then, one of management of peers and peer organizations” (Crosby 1996: 1408).

Annex 10.1: Overview of the pattern of health financing policy achievements¹, and explanatory factors, 1994-1999

Policy achievements	Explanatory factors
Successful policy actions	
free care for pregnant women and children under six implemented quickly, improving access for at risk groups & gaining popular support for health reform	<div>⇒ policy readily available, & drew legitimacy, from ANC National Health Plan</div> <div>⇒ policy goal of equity as equal access matched the goal of broader, social change</div>

Policy achievements	Explanatory factors
	<ul style="list-style-type: none"> ⇒ Ministerial support ⇒ decisive leadership and action ⇒ perceived as simple and easy to implement ⇒ top-down & speedy implementation
free primary care implemented quickly, improving access for poorer, rural populations & gaining some popular support for health reform	<ul style="list-style-type: none"> ⇒ as above, plus ⇒ drew legitimacy, from ANC National Health Plan, Health Care Finance Committee and Committee of Inquiry
health sector geographic resource allocation formula speedily implemented, resulting in resource re-allocations towards formerly under-resourced provinces, and re-prioritisation of budgets in favour of primary care	<ul style="list-style-type: none"> ⇒ as above, plus ⇒ drew legitimacy from ANC National Health Plan and Health Care Finance Committee ⇒ policy goal of equity as geographical resource reallocations matched the goal of broader, social change ⇒ implemented through 'routine' process of budgeting
1998 Medical Schemes Act passed with potential to tackle problems within private sector (subject to development of appropriate regulations and enforcement of them), and so have positive equity & sustainability consequences	<ul style="list-style-type: none"> ⇒ perceived as simple to implement ⇒ line of policy action available from Committee of Inquiry analysis & recommendations ⇒ goals of promoting equity within private sector & controlling cost inflation create legitimacy ⇒ driven by technicians initially, with subsequent Ministerial support ⇒ careful & deliberate 'consultation' strategy with relevant stakeholders
Weaknesses of policy actions	
fee removal implemented in ways that undermined sustainability in short term (changes in preventive/curative utilisation patterns) and long-term (provider morale)	<ul style="list-style-type: none"> ⇒ policy developed in a time of radical change when careful planning not possible ⇒ political goals & vision given greater importance than careful planning for implementation (taking advantage of a window of opportunity) ⇒ fee design of Free Care 1 did not ensure appropriate incentives to utilisation across levels of care ⇒ top-down implementation approach ⇒ limited understanding of, and capacity for, health economics analysis within DOH
fee removal appeared to undermine the basis for a hospital-plus-PHC benefit package for S/NHI which has greater potential than hospital-only package to gain support and promote allocative efficiency	<ul style="list-style-type: none"> ⇒ health equity goal primarily understood as equal access only ⇒ secure, short-term access gains given greater weight than longer-term actions with unknown benefits ⇒ limited understanding of potential role of N/SHI (and public hospitals) in promoting equity and sustainability within overall health system development within DOH ⇒ limited understanding of, and capacity for, health economics analysis within DOH
implementation of health sector resource allocation formula undertaken too quickly, causing immediate budget problems for provinces which create an environment for budgeting gaming, undermines capacity and has potential to create equity and sustainability problems	<ul style="list-style-type: none"> ⇒ policy developed in a time of radical change when careful planning not possible ⇒ political goals & vision of greater importance than careful planning for implementation (taking advantage of a window of opportunity) ⇒ limited understanding of how health system operate (e.g. constraints on moving resources etc) ⇒ limited understanding of, and capacity for, health economics analysis within DOH
health sector resource allocation formula did not deal effectively with level of care issues, creating problems for subsequent approaches in health sector	<ul style="list-style-type: none"> as above, plus ⇒ policy design requirements more complex than perceived ⇒ lack of necessary information to support design
Gaps in policy action	
lack of norms and standards for the health sector, and slow development of conditional grants, to be used in protecting health budgets within provinces and promoting inter-provincial equity (fiscal federalism may, therefore, threaten initial resource reallocations)	<ul style="list-style-type: none"> ⇒ continuing process of structural transformation & evolution of national/provincial relationships makes policy development difficult ⇒ provincial contexts & capacities make action difficult ⇒ complex & difficult area for policy development so policy development slow/weak ⇒ lack of decisive leadership & action

Policy achievements	Explanatory factors
	<ul style="list-style-type: none"> ⇒ some conflicts between actors over nature of conditional grants/norms and standards to be applied, and goals pursued ⇒ DOF strong pursuit of efficiency concerns (driven by GEAR) ⇒ limited political/public oversight and review of resource allocation and budgets at national or provincial level ⇒ limited understanding of, and capacity for, health economics analysis within DOH and at provincial level
health resource allocation policy has not addressed problems of intra-provincial resource allocation inequities, also causing sustainability problems within provinces	<ul style="list-style-type: none"> ⇒ provincial contexts & capacities make action difficult ⇒ lack of decisive leadership & action ⇒ complex policy area perceived as of low priority ⇒ limited understanding of, and capacity for, health economics analysis within DOH and at provincial level ⇒ limited political/public oversight and review of resource allocation and budgets at national or provincial level
as no N/SHI proposal has reached the stage of implementation, there has been no action to bring about the private/public cross-subsidies required to tackle inequities and address the funding gap of the public health sector	<ul style="list-style-type: none"> ⇒ complex and difficult area of policy development ⇒ opposition of critical actors, especially former Minister of Health, DOF, trade unions ⇒ differences between actors around understanding of equity & how to pursue it ⇒ special processes established to consider policy action had critical weaknesses (e.g. limited access to Minister, outside routine decision-making) ⇒ technicians failed to strategise effectively in support of own proposals ⇒ technical analysis not always adequate/appropriate ⇒ limited understanding of, and capacity for, health economics analysis within DOH and at provincial level
slow progress in implementing uniform hospital fee system reflects broader failure to tackle hospital management issues, with negative consequences for equity and	<ul style="list-style-type: none"> ⇒ hospitals low priority area for policy development ⇒ limited implementation focus within policy development of Hospital Strategy Project ⇒ lack of decisive leadership and action ⇒ weaknesses in provincial capacity to implement ⇒ limited understanding of, and capacity for, health economics analysis within DOH and at provincial level
little development of the organisational capacity necessary to implement policy change, itself contributing to sustainability and equity problems	<ul style="list-style-type: none"> ⇒ complex area for policy action ⇒ weak leadership for implementation ⇒ undermined by continuing process of structural transformation ⇒ undermined by resource constraints/inflexibility imposed by GEAR ⇒ undermined by continuing centralisation of decision-making ⇒ few people with relevant skills

Notes:

1. Successful policy action = policy change achieved which at least has the potential for equity and sustainability gains.

Annex 10.2: Strengthening the processes of health care financing development and implementation in South Africa (with specific reference to SHI and Norms and Standards)

<p align="center">STRENGTHENING POLICY FORMULATION AS A FOUNDATION FOR IMPLEMENTATION (SECTION 10.2)</p>
<p>1. Supporting leadership with technical analysis</p> <ul style="list-style-type: none"> • To strengthen future policy development, it may be useful for policy makers and technicians/analysts to map out the financing topics of focus in policy development over the next term of government. This could help ensure that appropriate research and information is available at the right time (including data and analysis from monitoring and evaluation of previous reforms). • The existing structures for channeling information and advice to the national Minister of Health and senior civil servants might be reviewed with an eye to ensuring a more routine and speedy flow of ideas, and more regular contact with the Directorate of Health Financing and Economics. • Opening up broader policy debates would be an important step in bringing a wider range of views to bear on health care financing policy development.
<p>(a) Strengthening health economics capacity within government</p> <ul style="list-style-type: none"> • It may be useful to sensitise high level officials in the national and provincial health departments to the importance and relevance of health economics skills in health reform. • Mid-level managers need to be aware of the uses and scope of health economics so that they can commission useful work and know how to interpret its results. • Better communication between policy makers and technicians on the issues that are important may facilitate policy development in key areas. • It will be important for the existing Directorate of Health Financing and Economics to link closely with other units within government which have complementary skills, such as legal, actuarial and broad policy analysis skills. This Directorate will also continue to need to access to the highest levels of government to play its role effectively. Formal mechanisms of co-ordination and channels of communication may be required, but members of the Directorate will also need to develop informal channels. • The need for provincial level capacity in health economics and policy analysis should be reviewed in order to identify capacity development needs at this level. • Skills' development of young economists and of public health professionals is vital for future capacity creation and needs special attention including intensive training and mentoring, perhaps in a collaborative government/academic setting, to allow learning through experience. Such initiatives would need to be developed by the relevant actors.
<p>(b) Working with non-government analysts</p> <ul style="list-style-type: none"> • There may be value in reviewing the nature of collaboration between internal government technicians and external analysts in relation to current and emerging priority issues, in order to ensure that necessary analytical work is undertaken, as well as helping to avoid duplication and irrelevance in on-going research. Collaboration might take the form of regular joint meetings, review of work plans and/or joint activities. Regular joint meetings will help foster communication and trust. • Better communication between policy makers, internal technicians and external analysts around priority issues may also support the development of joint agendas or work-plans that will facilitate policy development in key areas. • Health economists outside government may also need to review and develop their role as 'critical allies', supportive but independent of government. This might include prompting broader debate on the role of civil society in support of government.
<p>2. Developing the strategic skills and tactical awareness of technicians</p> <ul style="list-style-type: none"> • Policy-makers and technicians inside government must appreciate the value of policy analysis skills in strengthening policy development strategies around current priority issues, such as SHI and norms and standards. Working with other that have such skills may, however, better ensure the development of effective strategic action. • Analysts outside government should consider how to 'market' their work in ways that strengthen its potential to inform policy issues of current concern, without undermining its perceived

<p>integrity. This might include discussion with the technicians working inside government, as they represent one potential 'policy champion' of relevant analytical work. Other strategic action such as lobbying, presentations to top policy makers, refutation of counter arguments and publication of findings through various media may also help to promote the research findings onto the policy agenda.</p>
<p>(a) Actively addressing the values of policy elites</p> <ul style="list-style-type: none"> • In developing future social insurance and resource allocation proposals, technicians and analysts need to understand, and actively engage with, the different notions of equity held by various policy-making groups within the national Departments of Health and Finance, and at provincial level. • Analysis in support of social health insurance should also consider motivations and objectives of cross-subsidisation in health care spending within the context of South Africa's past history and present social objectives. • A broader and open policy process might also allow wider consultation and consensus building on the meaning of equity, and on the trade-offs required in implementing policy action in pursuit of equity.
<p>(b) Developing effective and appropriate strategies for engaging critical actors</p> <ul style="list-style-type: none"> • Better communication and consultation with the DOF is important for future policy development and must be rooted in better technical analysis by the DOH, working with (if not always only within) national policy frameworks. • In taking forward SHI policy development it will be important to develop an explicit consultation and negotiation strategy with the employees/Trade Unions, as well as to try and 'engage' constructively the hostile private sector groups (even if only to be seen to be responsive). • The processes used by the Medical Schemes Working Group provide a useful model of negotiation in relation to policy development for further consideration. • It may be useful to review the merits of using special and routine policy processes in developing policy around SHI and Norms and Standards. Despite the experience of the past there may be value in both cases in seeking a broader range of options through some form of special process, rather than sticking to existing ideas within routine processes. There may even be a stronger argument for going outside routine processes in relation to Norms and Standards than in relation to SHI.
<p>(c) Improving the communication of complex policy design</p> <ul style="list-style-type: none"> • SHI debates need to be opened for broader discussion by spelling out key objectives, broad policy options and even detailed design options simply and clearly. • The first step in developing norms and standards to guide resource allocations must also be to spell out key objectives and options. • International (and, where relevant, national) experiences might also be used to clarify by example both areas of policy development.
<p>3. Building implementation concerns into policy development</p>
<p>(a) Involving implementers in policy design</p> <ul style="list-style-type: none"> • Representatives of senior and middle level managers, as well as provider groups, should be involved in developing policies around social health insurance, norms and standards and hospital user fee reforms. They should, however, act more as advisers in the policy design phase, and then take a more central role in developing implementation plans. • The design of both SHI and norms and standards must specifically take account of any potential opposition from implementers.
<p>(b) Strengthening the link of 'special policy processes' to implementation</p> <ul style="list-style-type: none"> • If special processes are used to take forward policy development of either SHI or Norms and Standards, attention must be given to how to channel its findings forward to implementation – perhaps by identifying an explicit 'policy champion'.

STRENGTHENING IMPLEMENTATION DIRECTLY (SECTION 10.3)
1. Working within a changing policy environment
<ul style="list-style-type: none"> • As the policy environment is still in transition, care priorities for financing policy development must be set to allow effective action. • Policy development must also continually take into account what institutional capacity is required for implementation and how to develop it. This might be through the design of SHI schemes or by working through, and so strengthening, newly evolving policy mechanisms such as the MTEF task team and '4x4'.
2. 'Enabling' implementation through leadership
<ul style="list-style-type: none"> • The activities of the mechanisms that currently co-ordinate the national and provincial departments of health on budgeting issues, particularly the MTEF Task Team and the '4x4', should be subject to regular review and adapted as necessary to maintain their effectiveness. A focus on equity issues should be established as part of their review of budgets. • If not already, financing should be a standing item on the agenda of the Provincial Health Restructuring Committee (PHRC). This group should establish additional national/provincial linking mechanisms on specific issues as necessary. • The PHRC should review the existing sets of recommendations on strengthening financial management capacity within the health sector. Clear priorities should be established and the groups responsible for taking action identified. • In developing SHI proposals and approaches for ensuring real resource reallocation it will be important to involve implementer groups, including health care providers, in appropriate ways. Further consultation with such groups will also be vital in planning implementation strategies. • The Directorate of Health Financing and Economics must establish routine structures to ensure and strengthen links with other groups within the national DOH whose functions are important to the implementation of financing policies. Such contacts are also important in ensuring that the links between financing and other policies are considered in policy development. Relevant groups include those responsible for medical schemes' regulation, hospital development, information systems development and human resources management. Links may also be needed with other government agencies such as that responsible for local government development. • Strengthening the capacity for implementation requires clearer strategies for decentralising some critical responsibilities, such as human resource management. This will, in turn, require liaison with other government departments. • Joint national/provincial mechanisms for M&E of financing policies are an important aspect of capacity development.
3. Planning for implementation
(a) Carefully taking advantage of windows of opportunity
<ul style="list-style-type: none"> • Pre-planning of reform implementation is always important in promoting effective implementation – particularly allowing the most critical obstacles to be identified and so addressed before even implementation. Gradual implementation strategies are also important in allowing such obstacles to be tackled during implementation. • Efficient monitoring and evaluation systems for all reforms will help remedy any problems produced by speedy implementation (see later recommendation)
(b) Recognising that complex policies create implementation problems
<ul style="list-style-type: none"> • In developing proposals for SHI thought must be given to the sequencing in implementation, particularly of hospital management strengthening steps, necessary to allow implementation. • Policy makers and technicians need to develop a conceptual framework that clarifies individual components of Norms and Standards, and considers the sequencing of their implementation.
4. The importance of monitoring and evaluation
<ul style="list-style-type: none"> • Both national and provincial monitoring and evaluation systems must be developed. • The commitment to developing a system for compiling National Health Accounts is an important foundation for M&E activities. It will allow both public and private sector expenditure patterns to be regularly reviewed. Broad monitoring at this level must, however, be supplemented by additional mechanisms that encompass other sources of information and that allow individual reforms to be evaluated. <ul style="list-style-type: none"> • It will be important to strengthen existing systems for monitoring household health care

expenditure and utilisation patterns, such as the routine household surveys undertaken by Statistics South Africa.

- Studies of the overall progressivity of health care expenditure and provision are important both in developing current SHI policy and in monitoring the equity impact of policy change.
- For individual reforms progress should be monitored against objectives using key indicators. Evaluation of the 1998 Medical Schemes Act is particularly important.
- M&E systems must generate information on both progress towards objectives and problems in implementation, if they are to allow appropriate remedial action to be identified.
- Policy makers and technicians should be involved in designing monitoring and evaluation systems by indicating what information would be useful to them at what time, in relation to reform evaluation.
- Clear mechanisms must be established in which M&E results are routinely discussed. These should be both within the national DOH and in bodies that bring together national/provincial groups.
- The existing health information systems must be strengthened to allow effective monitoring and evaluation of health financing policies.
- Non-government analysts could play a role in developing appropriate M&E procedures, and in conducting some of the periodic evaluations likely to be necessary in assessing the success of complex financing reforms;
- Specific attention must be given to gaining public views on reform impacts and to drawing these views into further policy development.

Annex 10.3: Summary of international experience concerning the ways in which SHI may have positive and negative impacts on equity, efficiency and sustainability

POSITIVE IMPACTS	NEGATIVE IMPACTS
1. Ways of affecting equity	
<ul style="list-style-type: none"> • People previously unable to afford private cover are now insured as risks are pooled and premiums are set according to income, especially when there is competition between schemes and when schemes are large • All scheme members have access to the same benefit package • Public sector funds previously consumed by those able to afford private care are released for caring for the indigent • Private patients using the public sector are no longer a drain on public sector funds as the scheme reimburses the public sector at a level equal to, or higher than, cost • The SHI fund contributes to the costs of caring for the indigent 	<ul style="list-style-type: none"> • Differentials in the type, extent and quality of health care services become more pronounced between the insured and the uninsured because net revenue gains are not targetted at the poor or better quality services are used as incentives for compliance • Inequities exist between the insured as a result of regressive subsidisation by employers or government, different risk pools for different schemes, and ceilings on contribution rates which are set too low • Higher prices are faced by the uninsured who do not qualify for public care, and by members of small schemes with high risk profiles, as they do not benefit from large risk pools • Total consumption of national health care resources by the insured increases disproportionately due to high utilisation, with high income contributors benefiting the most • The insured capture public subsidies to the indigent by using public facilities when the reimbursement rates paid by the scheme are too low • Expensive insured patients are “dumped” on the public sector • Extra government funds are consumed by the insured when the government is a major employer • Personnel drain to the private sector which is more stable and lucrative under SHI • Personnel discriminate against beneficiaries who are subsidised by the state • Services for the insured remain geographically inaccessible or inappropriate, especially in rural areas • Utilisation rates are lower for the poorer insured, due to cost-sharing policies or other financial burdens (such as travel costs) • The wealthier insured use private care not covered by SHI to avoid rationing mechanisms, such as queues, at SHI facilities • The benefits of risk-pooling are limited when people are allowed to opt out of belonging to a scheme, especially when they still make use of public care
2. Ways of affecting efficiency	
<ul style="list-style-type: none"> • Employer and employee representatives on scheme boards put pressure on the scheme administrators to control costs while maximising benefits • SHI promotes technical efficiency through forcing schemes to work within the constraints of community rating and mandated benefit packages and premiums, and to sometimes compete on the basis of price • Allocative efficiency is also promoted 	<ul style="list-style-type: none"> • SHI has high administrative costs • Cost control and fraud prevention may be weak if there is insufficient institutional capacity • SHI encourages over-utilisation by beneficiaries, especially of costly services • Several reimbursement mechanisms under SHI can encourage supplier-induced demand • If schemes are only allowed to compete on the basis of quality there is an incentive to increase specialist and high technology care which increases costs • Preventive care is neglected • Fragmentation is encouraged

<p>through these means</p> <ul style="list-style-type: none"> • Large schemes have the power to bargain with providers to drive down costs • Patients are in a stronger relationship viz-a-viz providers, as the fund supports them in making cost-effective health care choices while providers have strong incentives to retain patients in order to secure incomes • Risk-pooling limits “dumping” of patients on the public sector • Payroll-based contributions are cheaper to administer than a user fee system • The sales promotion costs of voluntary insurance are avoided because membership of a pre-determined SHI is mandatory • Improved health information systems are encouraged 	<ul style="list-style-type: none"> • Innovation is stifled in the attempt to create uniform norms for care • Cost control is limited when there is insufficient competition • Cost savings are limited when risk pools are too small • Public services will still subsidise private patients if reimbursement rates are set too low • The political power of interest groups, including government, may prevent cost-effective measures being introduced
<p>3. Ways of affecting sustainability</p>	
<ul style="list-style-type: none"> • Additional resources are raised for health care from a stable source • The flow of funds is visible, quantifiable and earmarked for health care, making planning for health care easier • Political support for a scheme is achieved through a variety of mechanisms: <ul style="list-style-type: none"> * coverage is extended * quality of care, including provider responsiveness, improves * providers gain access to better technology and secure incomes * employers experience improved labour relations * the accountability of schemes to contributors and to government improves, relative to private insurance 	<ul style="list-style-type: none"> • The scheme may collapse if costs exceed revenues because benefit packages and premiums are not calculated correctly • The scheme may collapse if it is administered inefficiently • Dissatisfaction with a scheme may destabilise the scheme and even the government. Reasons for dissatisfaction may be: <ul style="list-style-type: none"> * Providers resist limits on incomes and clinical freedom * The currently insured may resist extension of coverage and increases in premiums * The newly insured may resist being obliged to pay contributions, especially when the perceived quality of care is low * The business community may resist an additional tax burden * Government may feel that it loses the opportunity to control resource allocation and service delivery directly • The scheme may not be a sustainable mechanism for addressing health care problems more generally

Source: Doherty 1997a

Annex 10.4: Designing mechanisms for improved cross-subsidisation from private to public sectors in South Africa

ACTIVITY	OBJECTIVE
1. Clarifying policy options	
<ul style="list-style-type: none"> Detailed analysis of the overall progressivity of the current tax system Benefit-incidence analysis of health care provision to different income categories 	Clarify the direction and level of the present cross-subsidisation between the private and public sectors, in order to inform SHI policy (with respect to the cross-subsidisation it would be justifiable to attempt to achieve)
<ul style="list-style-type: none"> Evaluate the equity impacts of different SHI options (i.e. the progressivity of the contribution structure, also taking into account the extent to which SHI contributions would replace current out-of-pocket or other contributions to health care) Evaluate the overall progressivity of the system under different SHI options, using the above plus an assessment of the potential net change in public sector resources for health services <p><i>Both of these analyses would need to take account of developments with respect to social security contributions in general</i></p>	<ul style="list-style-type: none"> Clarify the extent to which each option (especially the one developed by the DOH in 1997) achieves this allowable cross-subsidisation in order to clarify which SHI option is more desirable from an equity perspective
<ul style="list-style-type: none"> Actor and willingness-/ability-to-pay analyses (especially in relation to employers, employees and unions in particular) 	<ul style="list-style-type: none"> Clarify the extent to which different SHI options are acceptable and affordable Clarify how hospital user fee policy (including hotel or other services for paying patients) should be linked to the implementation of SHI
2. Developing the design of a chosen policy option	
<ul style="list-style-type: none"> Develop a mechanism to collect fees charged to medical schemes for public hospital services consumed by members 	<ul style="list-style-type: none"> Improve the collection of fees which are currently charged but which, due to problems which are relatively easy to address, are not collected effectively
<ul style="list-style-type: none"> Evaluate the equity and revenue generating potential of proposed fee structures 	<ul style="list-style-type: none"> Ensure that proposed fee structures are appropriate in terms of equity objectives, and minimise aspects which could hinder implementation
<ul style="list-style-type: none"> Develop a revenue retention policy 	<ul style="list-style-type: none"> Ensure that hospitals have incentives to improve their fee collection systems, whilst also ensuring a redistribution of resources on an equitable basis and to lower levels of care
<ul style="list-style-type: none"> Re-design fee collection systems 	<ul style="list-style-type: none"> Ensure that new fee policies result in improved fee collection
<ul style="list-style-type: none"> Develop a policy on what special amenities may be offered to paying patients in public hospitals 	<ul style="list-style-type: none"> Ensure that paying patients have incentives to use public hospitals without jeopardising basic equity principles
<ul style="list-style-type: none"> Design the introduction of SHI to follow the implementation of hospital fee reform 	<ul style="list-style-type: none"> Ensure that the acceptability of SHI is enhanced by the development of a culture of payment as well as improved services in public hospitals
<ul style="list-style-type: none"> Re-consider administering SHI through existing medical schemes and introduction of a risk equalisation mechanism Re-consider opening SHI coverage to include PHC and a choice of provider 	<ul style="list-style-type: none"> Strengthen the sustainability of the SHI policy
3. Developing evaluation strategies to inform future policy design	
<ul style="list-style-type: none"> Evaluate risk-selection practices that may persist following implementation of the 1998 	<ul style="list-style-type: none"> Inform future policy development aimed at closing loop-holes in legislation preventing

Medical Schemes Act and its associated regulations	risk-selection practices
<ul style="list-style-type: none">• Evaluate the equity impact of the Act	<ul style="list-style-type: none">• Judge whether the new legislation achieves its objective of improving equitable access to care in order to determine whether further equity-promoting policies are required
<ul style="list-style-type: none">• Evaluate changes in utilisation prompted by the Act	<ul style="list-style-type: none">• Identify distortions that may result from limiting cover to hospital care• identify any changes in the relative utilisation of public and private hospitals
<ul style="list-style-type: none">• Evaluate the sustainability of the medical schemes industry in the new environment	<ul style="list-style-type: none">• Determine whether the new legislation promotes sustainable improvements in the medical scheme industry and, if not, prompt further policy development (including SHI)

REFERENCES

- Abel-Smith B. 1991. Financing health for all – is insurance the answer? *World Health Forum*. 7: 3-32.
- Adelzadeh A. 1996. *GEAR: neo-liberalism in RDP clothing*. Johannesburg: National Institute of Economic Policy.
- African National Congress. 1993. *A National health plan for South Africa- first draft*. Johannesburg: African National Congress.
- African National Congress. 1994a. *A National Health Plan for South Africa*. (Prepared by the ANC Health Department, with support and technical assistance of WHO and UNICEF). Maseru: Baar Mapping and Printing
- African National Congress. 1994b. *The Reconstruction and Development Programme: A policy framework*. Cape Town: ABC printers.
- Akin J, Birdsall N, and de Ferranti D. 1987. *Financing health services in developing countries: An agenda for reform. A World Bank Policy Study*. Washington, D.C.: The World Bank
- Akin JS, Griffin CC, Guilkey DK, and Popkin BM. 1986. The demand for adult outpatient services in the Bicol region of the Philippines. *Social Science and Medicine*. 22: 321-328.
- Barnum H and Kutzin J. 1993. *Public hospitals in developing countries: Resource use, cost, financing*. Baltimore: The Johns Hopkins University Press for the World Bank.
- Bennett S., Russell S. and Mills A. 1996. *Institutional and economic perspectives on government capacity to assume new roles in the health sector: A review of experience*. PHP Departmental Publication No. 22. London: London School of Hygiene and Tropical Medicine
- Berman P. 1997. National health accounts in developing countries: Appropriate methods and recent applications. *Health Economics* 6:11-30.
- Birdsall N. 1985. *Cost recovery in health and education: Bank policy and operations*. Washington, D.C.: Population, Health, and Nutrition Department, World Bank.
- Bourne D. 1994. *Analysis of mortality data for 1990*. Unpublished report prepared for the South African Health Expenditure Review, 1992/93.
- Bourne D.E., Pick W.M. Taylor S.R., McIntyre D.E., and Kloppe J.M. 1990. A methodology for resource allocation in health care for South Africa: Part III. *South African Medical Journal*. 77(9): 456-459.
- Brijlal V. 1999. *Application of minimum norms and standards in education: Review of policy document*. Johannesburg: Centre for Health Policy (unpublished document).
- Brijlal V and Gilson L. 1997. *Understanding capacity: Financial management within the District Health System* CHP Report. Johannesburg: Centre for Health Policy.

- Brijlal V, Gilson L, Makan B, and McIntyre D. 1997. *Tender contract to provide technical assistance to provinces with obtaining equity in district financing. Report submitted to the National Department of Health District Financing Task Team.* Johannesburg: Centre for Health Policy and Cape Town: Health Economics Unit.
- Brinkerhoff D. 1996. Process perspectives on policy change: highlighting implementation. *World Development* 24(9): 1395-1401.
- Budlender D. 1997. Introduction. In Budlender D (ed.) *The Second Women's Budget* Cape Town: Institute for Democracy in South Africa.
- Budlender D. 1998. *The People's Voices. National Speak Out on Poverty Hearings, March-June 1998.* Convened by the Commission for Gender Equality, the South African Human Rights Commission and the South African NGO Coalition. Johannesburg: Shereno Printers.
- Cassels A. 1995. Health sector reform: key issues in less developed countries. *Journal of International Development* 7(3): 329-348
- Central Statistical Services. 1997. *Census: Preliminary estimates of the size of the population of South Africa.* Pretoria: Central Statistical Services.
- Centre for Health Policy. 1990. *The great nationalisation debate: the case of private health care.* Briefing document. Johannesburg: Centre for Health Policy.
- Centre for the Study of Health Policy. 1989. *Privatising hospitals is bad for your health.* Briefing document. Johannesburg: Centre for the Study of Health Policy.
- Centre for the Study of Health Policy. 1990. *Policy studies for political change: an immediate priority.* Briefing document. Johannesburg: Centre for the Study of Health Policy.
- Cloete F. 1998. Cradle or death of democratic development? In: de Villiers, B (ed.). *State of the Nation 1997/98.* Pretoria: Human Sciences Research Council.
- Collins C. and Green A. 1994. Decentralisation and primary health care: some negative implications for developing countries *International Journal of Health Services* 24: 459-475
- Collins DH., Quick JD., Musau S. and Kraushaar DL. 1996 *Health financing reform in Kenya: the rise and fall of cost sharing.* Stubbs Monograph Series No.1, Boston: Management Sciences for Health.
- Coovadia H.M. 1988. The case for a national health service: A framework for discussion. In: Owen C.P. (ed.) *Towards a national health service. Proceedings of the 1987 NAMDA conference.*
- Creese A and Kutzin J. 1995. *Lessons from cost-recovery in health.* Forum on Health Sector Reform, Discussion Paper No. 2. Geneva: World Health Organisation.
- Crosby BL. 1996. Policy Implementation: The Organizational Challenge *World Development* 24: 1403-1415
- Crosby BL. 1997. Stakeholder analysis and political mapping: Tools for successfully implementing policy reforms. *Policy Studies and Developing Nations* 5: 261-286.

de Beer C. 1988. *A health service for the future - some utopian thinking*. Monograph no. 5. Johannesburg: Centre for the Study of Health Policy.

de Beer C. and Broomberg J. 1990a. Financing health care for all: Is national health insurance the first step. *South Africa Medical Journal*. 78(3): 144-147.

de Beer C. and Broomberg J. 1990b. Financing health care for all: Is national health insurance the first step. *Critical Health*. Number 31/32: 26-29.

de Beer C. and Broomberg J. 1990c. *Financing health care for all: Is national health insurance the first step on the road to health care for all*. Monograph no. 21. Johannesburg: Centre for the Study of Health Policy.

de Beer C, Buch E. and Mavrandonis J. 1988. *A national health service for South Africa Part 1: A case for change*. Johannesburg: Centre for the Study of Health Policy.

de Bruyn J. and Budlender D. 1998. Intergovernmental fiscal relations. In Budlender D (ed) *The Third Women's Budget*. Cape Town: Institute for Democracy in South Africa.

de Bruyn J, McIntyre D, Mthethwa N, Naidoo K, Ntenga L, Pillay P, and Pintusewitz C. 1998. *Public expenditure on basic social services in South Africa*. Midrand: Financial and Fiscal Commission (for UNICEF and UNDP).

de Villiers B. 1998. Intergovernmental relations in South Africa. In: de Villiers, B (ed.). *State of the Nation 1997/98*. Pretoria: Human Sciences Research Council.

Department of Finance. 1994. *Budget Review, 22 March 1994*. Cape Town: Department of Finance.

Department of Finance. 1995. *Policy guidelines for managing special purpose funds, financed by earmarked government revenues*. Pretoria: Department of Finance.

Department of Finance. 1996. *Growth, employment and redistribution: a macro-economic framework*. Pretoria: Republic of South Africa.

Department of Finance. 1997. *The Medium Term Expenditure Framework. Report of the Health Sectoral Team*. Pretoria: Department of Finance.

Department of Finance. 1998a. *Budget 1999: Medium term expenditure guidelines*. Pretoria, Department of Finance.

Department of Finance. 1998b. *Budget Review 1998*. Cape Town: Department of Finance.

Department of Finance. 1999. *Budget Review 1999*. Cape Town: Department of Finance.

Department of Health. 1994. *The revised 1995/96 budget allocation*. Pretoria: Department of Health.

Department of Health. 1996a. *Annual Report*. Pretoria: Department of Health.

Department of Health. 1996b. *Budget allocation process during 1996/97 financial year*. Pretoria: Department of Health.

Department of Health. 1997a. *A social health insurance scheme for South Africa. A policy document*. Pretoria: Department of Health.

Department of Health. 1997b. *Reforming financing of private health care in South Africa: The quest for greater access and efficiency. A policy document*. Pretoria: Department of Health.

Department of Health. 1998. *1998 National antenatal HIV sero-prevalence survey*. Pretoria: Department of Health.

Department of Health/Health Policy Co-ordinating Unit. 1995. *A Policy for the Development of a District Health System for South Africa*. Johannesburg: Health Policy Co-ordinating Unit.

Department of Health and Social Security (DHSS). 1976. *Report of the Resource Allocation Working Party: Sharing resources for health in England*. London: Her Majesty's Stationary Office.

Department of Health and Social Security (DHSS). 1986. *Review of the Resource Allocation Working Party Formula. Report by the NHS Management Board*. London: Department of Health and Social Security.

Doherty J. 1997a. *Social Health Insurance*. Paper prepared for the SAZA project. Johannesburg: Centre for Health Policy.

Doherty J. 1997b. *Needs-based weighted capitation formulae*. Paper prepared for the SAZA project. Johannesburg: Centre for Health Policy.

Doherty J and van den Heever A. 1997. *A resource allocation formula in support of equity and primary health care*. Monograph No. 47. Johannesburg: Centre for Health Policy.

Doherty J and van den Heever A (forthcoming). *Redistributing health care resources on a geographic basis: lessons from South Africa. Social Science and Medicine*.

Duffy G. 1998. *The economics of South Africa's public debt problem*. Report prepared for South African Non-Governmental Organisation Coalition and Alternative Information Development Centre.

Ensor T. 1995. *Introducing health insurance in Vietnam. Health Policy and Planning*, 10(2): 154-163.

Fallon P and da Silva L. 1994. *South Africa: Economic Performance and Policies. Discussion Paper 7*. Johannesburg: The World Bank (Southern Africa Department).

Financial and Fiscal Commission. 1996. *Recommendations for the allocation of financial resources to the national and provincial governments for the 1997/8 fiscal year*. Midrand: Financial and Fiscal Commission.

Financial and Fiscal Commission. 1998. *Recommendations and Comments: The Allocation of Financial Resources to the National, Provincial and Local Governments for the 1998/99 Fiscal Year, Submitted in terms of Section 9 of the Intergovernmental Fiscal Relations Act, 1997*. Midrand: Financial and Fiscal Commission.

Frenk J. 1996. Comprehensive analysis for health system reform. In Berman P (ed). *Health Sector Reform in Developing Countries*. Boston: Harvard University Press

Friedman S and Reitzes M. 1996. Democratic Selections: Civil Society and Development in South Africa's New Democracy. Chapter 13 in: Maganya E and Houghton R. (ed) *Transformation in South Africa?: Policy debates in the 1990s*. Johannesburg, Institute for African Alternatives

Friedman S. and Atkinson D (eds). 1994. *South African Review 7. The small miracle: South Africa's negotiated settlement*. Johannesburg: Ravan Press.

Friedman S. 1998. It's policy skills that are lacking, not capacity. *Synopsis* 2(3): 4-5

Gevisser M. 1996. *Portraits of Power: Profiles in a changing South Africa*. Claremont: David Philip in association with Mail and Guardian

Gilson L. 1997a. The lessons of user fee experience in Africa. *Health Policy and Planning* 12(4): 273-285.

Gilson L. 1997b. *Implementing and evaluating health reform processes: Lessons from the literature* Major Applied Research: Working Paper No.1, Washington: Partnerships for Health Reform.

Gilson L. 1998a. *Re-addressing equity: the search for the holy grail? The importance of ethical processes*. Paper presented to the Eighth Annual Public Health Forum, "Reforming Health Sectors", London School of Hygiene and Tropical Medicine, 21st-24th April 1998.

Gilson L. 1998b. In defence and pursuit of equity *Social Science and Medicine* 47(12): 1891-1896.

Gilson L and Mills A . 1996. Health sector reform in sub-Saharan Africa: Lessons of the last ten years in Berman P (ed.) *Health Sector Reform in Developing Countries*. Boston: Harvard University Press.

Gilson L. and Travis P. 1997. *Health system decentralization in Africa: An overview of experiences in eight countries*. Paper prepared for WHO regional seminar on decentralization, Bamako, Mali, January 1997

Gilson L. and McIntyre D. 2000. Experiences from South Africa: dealing with a poor health legacy of apartheid. In: Whitehead M, Evans T, Diderichsen F and Bhuiya A (eds). *Challenging inequities in health: From ethics to action*. New York: Oxford University Press.

Gilson L, Kilima P and Tanner M. 1994. Local government decentralisation and the health sector in Tanzania. *Public Administration and Development* 14(5): 451-478.

Gilson L, Morar R, Pillay Y, Rispel L, Shaw V, Tollman S, and Woodward C. 1996. *Decentralisation and health system change in South Africa*. National report prepared as part of the WHO cross-national study on decentralisation and health system change. Johannesburg: Health Policy Co-ordinating Unit.

Gilson L., van den Heever A., Brijlal V. 1997. *DHS development in the North West Province: District Financing and Financial Management*. Report to the Health Systems Trust, Johannesburg: Centre for Health Policy.

- Gish O. 1990. Some links between successful implementation of primary health care interventions and the overall utilisation of health services. *Social Science and Medicine*: 30(4): 401-405.
- Glassman A, Reich M, Laserson K and Rojas F. 1999. Political analysis of health reform in the Dominican Republic. *Health Policy and Planning* 14(2): 115-126.
- Gottschalk K. 1998. The changing dynamics of policy making in government. In: de Villiers, B (ed.). *State of the Nation 1997/98*. Pretoria: Human Sciences Research Council.
- Govender M and McIntyre D. 1997. *An evaluation of the RDP Clinic Upgrading and Building Programme*. Unpublished input paper prepared for the Poverty and Inequality Report. Cape Town: Health Economics Unit, University of Cape Town.
- Government of South Africa. 1997. *The foundation for a better life has been laid: The government's mid-term report to the nation*. Pretoria: South African Communication Service.
- Grindle MS. and Thomas JW. 1991. *Policy Choices and Policy Change: The Political Economy of Reform in Developing Countries*. The Johns Hopkins University Press: Baltimore and London.
- Gross R, Rosen B and Chinitz D. 1998. Evaluating the Israeli health care reform: Strategy, challenges and lessons. *Health Policy* 45: 99-117.
- Gustafson D. and Ingle M. 1992. *Policy characteristics analysis*. Technical Notes No. 3. A publication of USAID's Implementing Policy Change Project.
- Haggard S and Webb S. 1993. What do we know about the political economy of economic policy reform? *The World Bank Research Observer* 8: 143-168.
- Health Care and Financing Committee. 1994. *Report of the Health Care Finance Committee to the Minister of Health*. Pretoria: Department of Health.
- Heintz J. 1999. *Growing pains mar process*. Published on the IDASA web site. <http://www.idasa.org.za>
- Heintz J. and Jardine C. 1998. *Poverty and economics in South Africa*. Paper presented for the South African NGO Coalition, the South African Human Rights Commission and the Commission for Gender Equality. Johannesburg: SANGOCO (occasional paper series).
- Hilderbrand ME. and Grindle MS. 1994. *Building sustainable capacity: challenges for the public sector*. Paper prepared for The United Nations Development Programme Pilot Study of Capacity Building. Harvard University, Cambridge: Harvard Institute of International Development.
- Hirschowitz R and Orkin M. 1995. *A national household survey of health inequalities in South Africa*. Johannesburg: Community Agency for Social Enquiry, for the Henry J. Kaiser Foundation.
- Human P and Strachan B. 1996. *Transformation of the public health sector: an assessment of managerial capacity and the implications for management development*. Cape Town: Department of Community Health, University of Cape Town.

Humphries R and Rapoo T (eds). 1994. *Governing the provinces*. Johannesburg: Centre for Policy Studies.

Institute for Democracy in South Africa. 1999. *Submission on National Budget 1999/2000 to the Portfolio Committee on Health*. Cape Town: Institute for Democracy in South Africa Budget Information Service.

Janovsky K and Cassels A. 1996. Health Policy and Systems Research: Issues, Methods, Priorities. In: Janovsky K. (ed) *Health policy and systems development: an agenda for research* Geneva: World Health Organisation.

Kohlemainen-Aitken R-L and Newbrander W. 1996. *Decentralizing the management of health and family planning programmes*. Boston: Management Sciences for Health.

Kraak G, Fiaizi G, and Smith B. 1996. *Development Update: an Interfund briefing on development and the voluntary sector in South Africa in 1995/6*. Johannesburg: Interfund.

Krafchik W and Weiner J. 1999. Capacity hampers parliament's potential amendment power. *Budget Watch*. June: 9-10.

Kutzin J. 1995. *Experience with organizational and financing reform of the health sector*. SHS Current Concerns Paper Number 8. Geneva: Division of Strengthening of Health Services, World Health Organization.

Kutzin J. 1998. Health insurance for the formal sector in Africa: "Yes, but...". In Beattie A., Doherty J., Gilson L., Lambo E. and Shaw P. *Sustainable Health Care Financing in Southern Africa*. Washington: World Bank

Lake S. 1997. *Pre-payment schemes in developing countries: an overview*. Paper prepared for the SAZA project. London: London School of Hygiene and Tropical Medicine.

Leichter HM. 1979. *A comparative approach to policy analysis: health care policy in four nations*. Cambridge: Cambridge University Press.

Leighton C. 1996. Strategies for achieving health financing reform in Africa. *World Development* 24(9): 1511-1525.

Lodge T. 1999. *South African politics since 1994*. Cape Town: David Philip Publishers.

Londono J-L. and Frenk J. 1997. Structured pluralism: towards an innovative model for health system reform in Latin America. *Health Policy* 41: 1-36.

Mackay S. 1998. Voters need more firepower. *Synopsis* 2(3): 1-5.

Maganya E. 1996. The contemporary development paradigm and South African policy-making in the 1990s. In: Maganya E, Houghton R (eds). *Transformation in South Africa? Policy debates in the 1990s*. Johannesburg: Institute for African Alternatives.

Magennis R. 1994. *Comments by Representative Association of Medical Schemes on the ANC National Health Plan (4th draft)*. Unpublished document. Johannesburg: Representative Association of Medical Schemes.

- Magongo B. and Cabral J. 1996. *Quality of care in PHC clinics in North-West and Northern provinces: Potential areas of action arising from the initial appraisal*. Unpublished report. Johannesburg: Centre for Health Policy.
- Makan B., Morar R., and McIntyre D. 1997. *DHS development in the Eastern Cape Province: District Financing and Financial Management*. Report to the Health Systems Trust. Cape Town: Health Economics Unit.
- Marais H. 1997. The RDP: is there life after GEAR? *Development Update* 1(1): 1-20.
- Marais H. 1998. *South Africa: limits to change. The political economy of transformation*. London and Cape Town: Zed Press/University of Cape Town Press.
- Marks S. 1998. The historical origins of national health services. In Owen C. P. (ed.) *Towards a national health service, proceedings of the 1987 NAMDA annual conference*.
- Matisonn J. 1998. How the ANC battled to balance the ideological books. *Mail & Guardian*; November 6 to 12: 16-17.
- May J (ed). 1998. *Poverty and inequality in South Africa*. Report prepared for Office of the Executive Deputy President and Inter-Ministerial Committee for Poverty and Inequality. Durban: Praxis Publishing.
- McCoy D. 1996. *Free health care for pregnant women and children under six in South Africa: an impact assessment*. Report prepared by the Child Health Unit, University of Cape Town. Durban: Health Systems Trust.
- McIntyre D. 1994a. *An analysis of the geographical distribution of public sector health care expenditure in South Africa*. Health Economics Unit Working Paper No. 7. Cape Town: Health Economics Unit, University of Cape Town.
- McIntyre D. 1994b. *User fees for public sector health services in South Africa: revenue generating potential and equity implications*. Health Economics Unit Working Paper No. 6. Cape Town: Health Economics Unit, University of Cape Town.
- McIntyre D. 1994c. *Mechanisms for the allocation of health care resources in South Africa: Report prepared for the Health Care Financing Work Group of the National Health Forum*. Cape Town: Health Economics Unit, University of Cape Town.
- McIntyre D. 1997a. *Health care financing and expenditure in South Africa: Towards equity and efficiency in policy making*. PhD dissertation. Cape Town: University of Cape Town.
- McIntyre D. 1997b. *Inequity in the South African health sector: Input paper for the Poverty and Inequality Report*. Cape Town: Health Economics Unit, University of Cape Town.
- McIntyre D. and Dorrington R. 1990. Trends in the distribution of South African health expenditure. *South African Medical Journal* 78(3): 125-129.
- McIntyre D and Gilson L. 1999. *Redressing dis-advantage: Promoting vertical equity within South Africa*. Paper presented at Second World Conference of the International Health Economics Association, Rotterdam, Netherlands, June 1999.

McIntyre D and Gilson L. (forthcoming). Putting equity in health back onto the social policy agenda: Experience from South Africa. *Social Science and Medicine*.

McIntyre DE, Bourne DE Klopper JM, Taylor SP, and Pick WM. 1991. A methodology for resource allocation in health care for South Africa. Part IV. Application of South African Health Resource Allocation formula. *South African Medical Journal*. 80(1): 139-145.

McIntyre D, Bloom G, Doherty J, and Brijlal P. 1995. *Health expenditure and finance in South Africa*. Durban: The Health Systems Trust and the World Bank.

McIntyre D, Baba L, and Mekan B. 1998. *Equity in public sector health care financing and expenditure in South Africa: an analysis of trends between 1995/96 to 2000/01. Technical report to Chapter 4 of the 1998 South African Health Review*. Durban: Health Systems Trust.

McIntyre D, Mbatsha S, Baba L and Thomas S. 1999. *Equity in public sector health care financing and expenditure in South Africa*. Submission for 1999 Health Systems Trust Annual Health Review. Cape Town: Health Economics Unit.

McPake B. 1993. User charges for health services in developing countries: A review of the economic literature. *Social Science and Medicine*. 36(11): 397-1405.

Medical Association of South Africa. 1994. *MASA's Policy Committee response to the ANC's second 'National Health Plan for South Africa'*. Unpublished document. Pretoria: Medical Association of South Africa.

Medical Research Council, MACRO International, Department of Health. 1999. *South Africa Demographic and Health Survey 1998*. Pretoria: Department of Health

Mogedal S, Steen SH, and Mpelumbe G. 1995. Health sector reform and organisational issues at the local level: lessons from selected African countries *Journal of International Development*, Special Issue 7(3): 349-368.

Monitor Company, Health Partners International, Centre for Health Policy, National Labour and Economic Development Institute. 1996. *Achieving equity, efficiency and accountability: A vision and strategy for South Africa's public hospitals*. Final report of the Hospital Strategy Project. Johannesburg: Monitor Company.

Mooney G. 1996. And now for vertical equity? Some concerns arising from Aboriginal health in Australia. *Health Economics*. 5: 99-103.

Mooney G. 1998. *Equity in future South African health care: A tale of minimally decent Samaritans or good South Africans?* Health Economics Unit Working Paper No. 28. Cape Town: Health Economics Unit, University of Cape Town.

Mwabu GM and Mwangi WM. 1986. Health care financing in Kenya: A simulation of welfare effects of user fees. *Social Science and Medicine*. 22(7): 763-767.

Ncayiyana D.J. 1994. Putting the horse before the cart. *South African Medical Journal*. 84(12): i.

Nelson J (ed). 1990. *Economic crisis and policy choice: the politics of adjustment in the Third World*. Princeton: Princeton University Press.

- Normand C and Weber A. 1994. *Social Health Insurance: A guidebook for planning*. Geneva: World Health Organisation and International Labour Office.
- Ntsaluba A. 1998. *The politics of health sector reform: South African experience*. Paper presented to the Public Health Forum 'Reforming Health Sectors', 21-24 April 1998, London.
- Ntsaluba, A. and Pillay Y. 1998. Reconstructing and developing the health system- the first 1000 days. *South African Medical Journal*. 88(1): 33-35.
- Olsen I.T. 1998. Sustainability of health care: a framework for analysis. *Health Policy and Planning* 13(3): 287-295.
- Owen C. P. (ed.) 1988. *Towards a national health service. Proceedings of the 1987 NAMDA annual conference*.
- Parsons W. 1995. *Public Policy: An introduction to the theory and practice of policy analysis*. Aldershot: Edward Elgar.
- Paul S. 1995. *Capacity Building for Health Sector Reform*. Forum on Health Sector Reform Discussion Paper No.5. Geneva: World Health Organisation.
- Picard J. 1992. *A national health service for South Africa Part II: A proposal for change*. Monograph no. 29. Johannesburg: Centre for Health Policy.
- Pilger J. 1997. *Apartheid did not die. A special report by John Pilger*. TV documentary screened on SABC, Channel 3. Carlton International Media Limited.
- Pintusewitz C. 1996. *Financial flows for health in the new intergovernmental system*. Paper presented at FFC workshop on Financial Flows. Midrand: Fiscal and Finance Commission.
- Portfolio Committee on Health. 1997. *The National Portfolio Committee on Health report*. Cape Town: Department of Health.
- Presidential Review Commission. 1998. *Developing a culture of good governance*. Report of the Presidential Review Commission on the Reform and Transformation of the Public Service in South Africa.
- Price M. 1999. Low-profile successes trump high-profile failures. *Frontiers of Freedom (South African Institute of Race Relations)* Fourth Quarter 1999: 28-32.
- Price M and de Beer C. 1989. Can privatisation solve the problems of the health sector? In Owen P (ed) *The Case for a National Health Service*. Cape Town: University of the Western Cape/National Medical and Dental Association.
- Rapoo T. 1994. *Rules and rulers: federalism, the RDP and the problem of power*. Transition Series: Vol 7(4). Johannesburg: Centre for Policy Studies.
- Rapoo T. Humphries R and Meierhenrich J. 1997. *Democracy in action: Democratic institutions and policy-making capacity in Gauteng*. Research report No. 53. Johannesburg: Centre for Policy Studies

- Reich M. 1996. The politics of health reform in developing countries. In: Berman P. (ed). *Health Sector Reform in Developing Countries*. Cambridge: Harvard University Press.
- Republic of South Africa. 1994. Debates of the National Assembly (Hansard), 20th October 1994.
- Republic of South Africa. 1995. Debates of the National Assembly (Hansard), 19th June 1995.
- Republic of South Africa. 1996. Debates of the National Assembly (Hansard) 4th June 1996.
- Republic of South Africa. 1997. *White Paper for the Transformation of the Health System in South Africa. (Towards a National Health System.) Government Gazette* 382(17910): Notice 667.
- Republic of South Africa. 1998. Debates of the National Assembly (Hansard), 4th May 1998.
- Rispel L., Price M and Cabral J. 1996. *Confronting need and affordability: Guidelines for Primary Health Care Services in South Africa*. Johannesburg: Centre for Health Policy
- Sabatier PA and Mazmanian D. 1979. The conditions of effective implementation: a guide to accomplishing policy objectives. *Policy Analysis* 5: 481-504
- Schneider H and Gilson L. 1999. The Impact of Free Maternal Health Care in South Africa. In: Berer M and Sundari Ravindran TK. *Safe Motherhood Initiatives: Critical Issues*. Oxford: Blackwell Science for Reproductive Health Matters.
- Schneider H, Kaka Z, Jina S, Koobair S, Kamalanathan J, Asmal E, and Peer A. 1997. *A survey to assess the impact of free primary health care on the Soweto Community Health Centres*. Johannesburg: Centre for Health Policy, University of the Witwatersrand.
- Schneider H. 1998. The Politics behind AIDS: The case of South Africa. In: Rosenbrock R. *Politics behind AIDS policies: Case studies from India, Russia and South Africa*. Berlin: Public Health Policy Unit.
- Shaw RP and Griffin CC. 1995. *Financing health care in Sub-Saharan Africa through user fees and insurance*. Washington, D.C.: The World Bank.
- Sidloyi S. 1996. Public service reform: a statistical analysis of the restructuring of the public service. In: Maganya E, Houghton R (eds). *Transformation in South Africa? Policy debates in the 1990s*. Johannesburg: Institute for African Alternatives.
- South Africa (Republic). 1995. *Restructuring the national health system for universal primary health care: Report of the Committee of Inquiry into a national health insurance system*. Pretoria: Department of Health. (Chairpersons: Dr J. Broomberg and Dr O. Shisana)
- Strachan B. 1995. *Finance and Budgeting: Submission to the SMT report on the health sector in the Province of the Western Cape*. Cape Town: Provincial Administration of the Western Cape.
- Swilling M and Woolridge D. 1996. Governance, administrative transformation and development in South Africa. In: Maganya E, Houghton R (eds). *Transformation in South Africa? Policy debates in the 1990s*. Johannesburg: Institute for African Alternatives.

- Tollman S. and Rispel L. 1995. Organisation, planning and management. In: Health Systems Trust. *South African Health Review 1995*. Durban: Health Systems Trust.
- Toye J. 1992. Interest group politics and the implementation of adjustment policies in sub-Saharan Africa. *Journal of International Development* 4: 183-197.
- Trostle J, Bronfman M and Langer A. 1999. How do researchers influence decision-makers? Case studies of Mexican policies. *Health Policy and Planning* 14(2): 103-114
- van den Heever A. 1994. *Paying for private health care: A report on the findings of the Melamet Commission*. Johannesburg: Centre for Health Policy.
- van den Heever A. and Brijlal V. 1997. Financing and Expenditure. In: *South African Health Review 1997*. Durban: Health Systems Trust.
- van den Heever A. Kinghorn A. and Beattie A. 1995. *Paying for health care: a comprehensive primary health care approach - An alternative to national health insurance*. Monograph no. 43. Johannesburg: Centre for Health Policy.
- van der Linde I. 1995. Zuma's guidelines on NHI. *South African Medical Journal* 85(2): 32.
- van Zyl A. 1998. Can provinces stick to budgets? *Budget Watch* 4(1): 3.
- van Zyl Slabbert, F. 1998. The process of democratisation: lessons and pitfalls. In: de Villiers B (ed.). *State of the Nation 1997/98*. Pretoria: Human Sciences Research Council.
- Vogel RJ. 1988. *Cost recovery in the health care sector: Selected country studies in West Africa*. World Bank Technical Paper No. 82. Washington, D.C.: The World Bank.
- Walt G. 1994. *Health Policy: An introduction to process and power*. London and Johannesburg: Zed Press and University of Witwatersrand Press.
- Walt G and Gilson L. 1994. Reforming the health sector in developing countries: the central role of policy analysis. *Health Policy and Planning* 9(4): 353-370.
- Welsh, D. 1998. Coalition government: an unwilling marriage? In: de Villiers B (ed.). *State of the Nation 1997/98*. Pretoria: Human Sciences Research Council.
- Wilkinson D, Gouws E, Sach M, and Abdool Karim SS. 1998. *Does removing user fees encourage attendance for curative services at the expense of preventive services?* Paper presented to the 16th Epidemiological Society of Southern Africa Conference, Midrand, 25-28 September.
- Working Group on National/Social Health Insurance. 1997. *Key policy issues and options*. Unpublished document.
- World Bank. 1993. *World Development Report: Investing in health*. Oxford: The Oxford University Press for The World Bank.
- World Bank. 1997. *World Bank Development Report 1997*. Washington: World Bank.
- Zwarenstein M. 1990. Is there a role for the private sector in South African health care? Yes, but not in the NHS. *Critical Health* 31/32: 30-32.

ADDITIONAL BIBLIOGRAPHY

Administrative Work Group to the MEC Committee. 1994/95. *Manual for the application of the uniform fees system for health services*.

Broomberg J, Price M. 1989. *Evaluating a medical aid scheme proposal*. Monograph 12. Johannesburg: Centre for the Study of Health Policy.

Broomberg J, Price M. 1989. *Towards an integrated health care financing and delivery scheme*. Monograph no.14. Johannesburg: Centre for the Study of Health Policy.

Centre for Health Policy. 1992. *A national health service for South Africa*. Briefing document. Johannesburg: Centre for Health Policy.

Centre for Health Policy. 1992. *A national health service for South Africa: The role of the general practitioner*. Briefing document. Johannesburg: Centre for Health Policy.

Centre for Health Policy. 1993. *The medical schemes amendment act: an appropriate response?* Briefing document. Johannesburg: Centre for Health Policy.

Centre for the Study of Health Policy. 1989. *Medical aids and the cost of health care: What happens next?* Briefing document. Johannesburg: Centre for the Study of Health Policy.

Centre for the Study of Health Policy. 1989. *The cost of private health care: explaining the crisis*. Briefing document. Johannesburg: Centre for the Study of Health Policy.

Centre for the Study of Health Policy. 1990. *Dismantling apartheid in health care*. Briefing document. Johannesburg: Centre for the Study of Health Policy.

COSATU, NACTU, FEDSAL. 1996. *Social equity and job creation: Proposals by the South African labour movement*. A policy document. Johannesburg: Nedlac Labour Caucus.

Critical Health 1990. Health and welfare in transition. A report on the Maputo Conference. Number 31/32.

de Beer C, Buch E. and Mavrandonis. 1988. *Introducing a national health service: obstacles to be overcome*. Monograph no. 4. Johannesburg: Centre for the Study of Health Policy.

Department of National Health and Population Development. 1990. *Policy on the allocation of health funds in the Republic of South Africa (including the self-governing territories)*. Pretoria: Department of National Health and Population Development.

Doherty J. 1996. *Issues in re-allocating resources in support of equity and PHC: a personal perspective*. Paper presented to the Finance and Fiscal Commission workshop on financial flows. Midrand: Finance and Fiscal Commission.

Doherty J. and Khuonoane B. 1995. *Financing health care for all: some alternatives*. Briefing document. Johannesburg: Centre for Health Policy.

Doherty J. and van den Heever A. 1997. Is there a role for a health formula in the new provincial budgeting system? *Health Systems Trust Update*. Issue No.24. Durban: Health Systems Trust.

Financial and Fiscal Commission. 1995. *Framework document for intergovernmental fiscal relations in South Africa*. Midrand: Financial and Fiscal Commission.

Financial and Fiscal Commission. 1995. *Recommendations for the allocation of Financial resources to the National and Provincial governments for the 1996/7 fiscal year*. Midrand: Financial and Fiscal Commission.

Financial and Fiscal Commission. 1996. *Financial and Fiscal Commission comment series: Critique of the Budget Council recommendations for the 1997/8 fiscal year*. Midrand: Financial and Fiscal Commission.

Financial and Fiscal Commission Comment Series. 1996. *The recommendations of the Budget Council: Implications for the provision of public services during the 1997/98 fiscal year*. Midrand: Financial and Fiscal Commission.

Gauteng Department of Health. 1995. *Revised management plan application for bridging finance for the provincial health service of Gauteng*. Johannesburg: Gauteng Department of Health.

Khosa, S. and Thomas E. 1995. "Free health care" policies. Chapter 14 in: *South African Health Review*. Durban: Health Systems Trust and the Henry J. Kaizer Foundation.

Makan B. McIntyre D., Gwala P., McCoy D., Khosa S. 1996. Financing and expenditure. Chapter 6 in: *South African Health Review 1996*. Durban: Fishwick Printers.

McCoy D. and Khosa S. 1996. "Free health care" policies. *South African Health Review 1996*. Chapter 14 in: *South African Health Review 1996*. Durban. Fishwick Printers.

Medium Term Expenditure Framework Working Group. 1997. *Draft health MTEF report*. Pretoria: Department of Finance.

Mills A. 1994. *Consultancy report to the Health Finance Committee*. Johannesburg.

Owen C. P. and Thomson (ed.). 1991. *People's health: The way forward*. Proceedings of the 1991 NAMDA Conference.

Owen C. P.(ed.) 1988. *Towards a national health service*. Proceedings of the 1987 NAMDA annual conference.

Owen C.P. (ed.). *The case for a national health service*. A series of lectures organised by extra-mural studies and NAMDA. Western Cape.

Price M. and Broomberg J. 1989. *What's wrong with medical aid schemes?* Monograph no. 13. Johannesburg: Centre for the Study of Health Policy.

Price M. and Masobe P. 1993. *The future of medical schemes: Issues and options for reform*. Monograph no. 32, Johannesburg: Centre for Health Policy.

Price M. and Tshazibane P. 1988. *Dilemmas posed by medical aid schemes for the labour movement*. Monograph 11. Johannesburg: Centre for the Study of Health Policy.

Price M., Khuonoane B., van den Heever A. 1996. *Should tax concessions on medical aid contributions be removed? A political-economic analysis*. Monograph 39. Johannesburg: Centre for Health Policy.

Rensburg van H.C. and Harrison D. 1995. History of health policy. Chapter 4 in: *South African Health Review*. Durban: Health Systems Trust and the Henry J. Kaiser Foundation.

Republic of South Africa. 1996. *National Assembly Portfolio Committee report- 1996*. Cape Town: Department of Health.

Rispel L. 1996. *Norms and standards for securing a system of resource allocation*. Paper presented at the Fiscal and Finance Committee workshop on financial flows. Midrand: Fiscal and Finance Committee.

Ruff B. 1997. Hospital Restructuring. Chapter 7 in: *South African Health Review 1997*. Durban: Health Systems Trust.

Segall M. 1996. *Medium term expenditure planning*. Paper presented at the Fiscal and Finance Committee workshop on financial flows. Midrand: Fiscal and Finance Committee.

van den Heever 1997. *A discussion of the Financial and Fiscal Commission's proposals for a provincial budgeting system*. Johannesburg: Centre for Health Policy.

van den Heever A. 1994. *Paying for private health care: a report on the findings of the Melamet Commission*. Monograph no. 37. Johannesburg: Centre for Health Policy.

van den Heever A. 1994. *Paying for Public Health Care*. Monograph. Johannesburg: Centre for Health Policy.

van den Heever A. 1996. *The budget process and the flow of funds to the provinces*. Paper presented at the FFC workshop on financial flows. Midrand: Fiscal and Finance Committee.

van den Heever A. 1997. *Conditional grants for health; with a special emphasis on the central hospitals, teaching and research grants*. Unpublished report produced for the Financial and Fiscal Commission. Johannesburg.

van den Heever A. and Doherty J. 1997. *Fiscal federalism and the health budget*. Johannesburg: Centre for Health Policy.